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2. Hess, W. R. Diencephalon. New York: Grune & Stratton, 1954.

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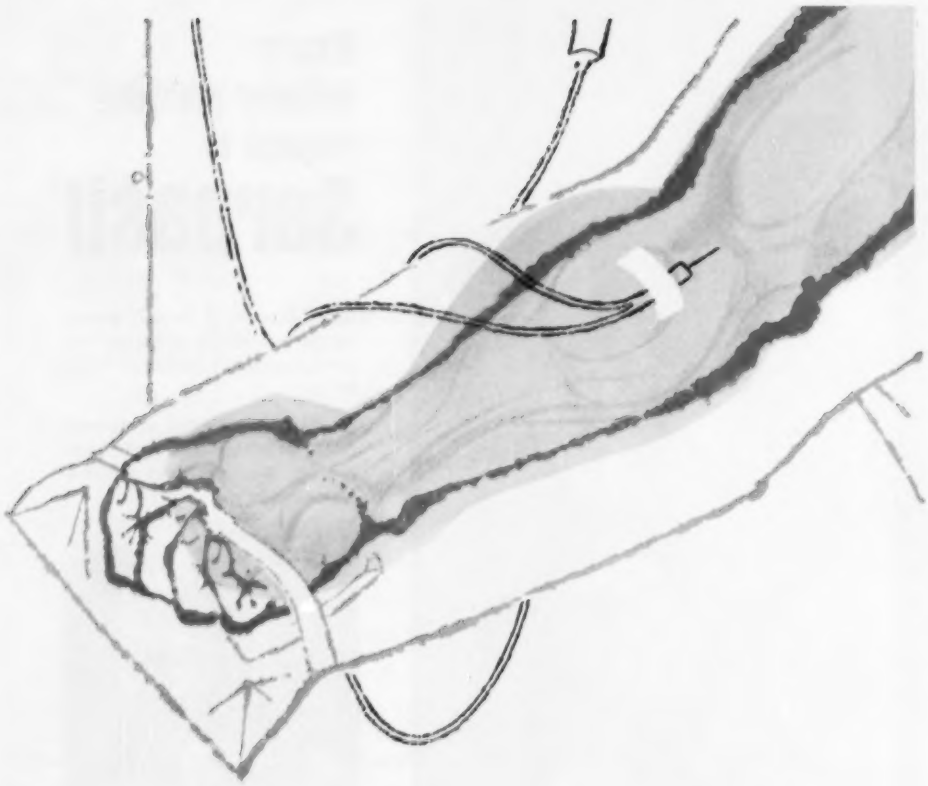

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1. Greenstein, L., and Sapirstein, M. R.: A. M. A. Arch. Neurol. & Psychiat. *70*:469 (Oct.) 1953. • 2. Smith, B., and Forster, F. M.: Neurology *4*:127 (Feb.) 1954. • 3. Smith, B. H., and McNaughton, F. L.: Canad. M. A. J. *68*:464 (May) 1953. • 4. Whitty, C. W. M.: Brit. M. J. *2*:540 (Sept. 5) 1953. • 5. Doyle, P. J., and Livingston, S.: J. Pediat. *43*:413 (Oct.) 1953. • 6. Timberlake, W. H., Abbott, J. A., and Schwab, R. S.: New England J. Med. *252*:304 (Feb. 24) 1955.

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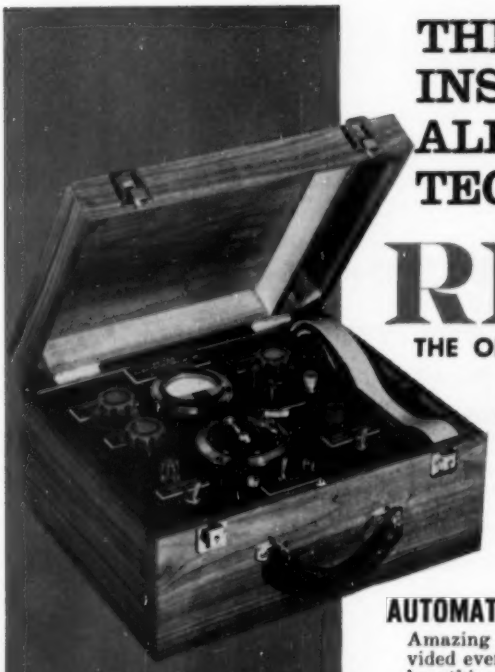

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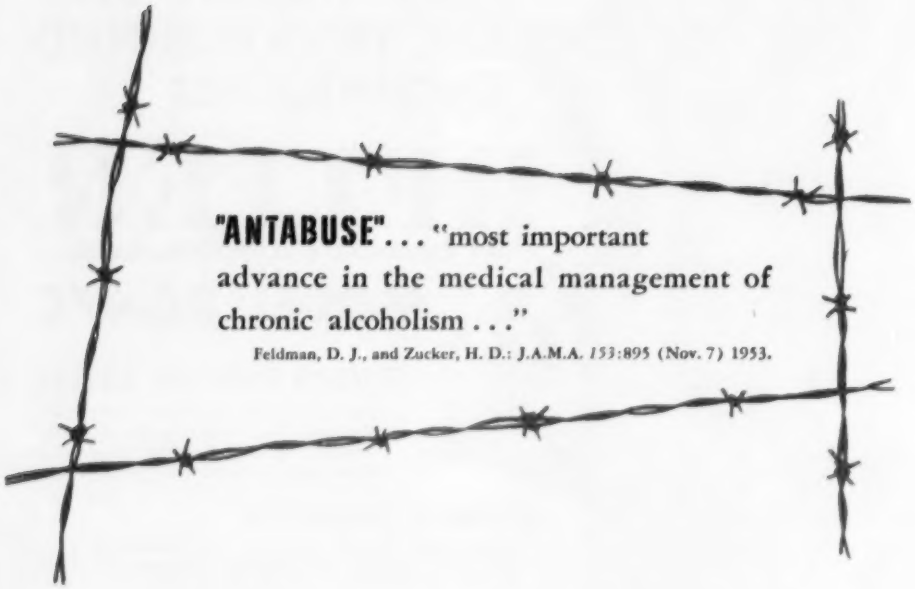

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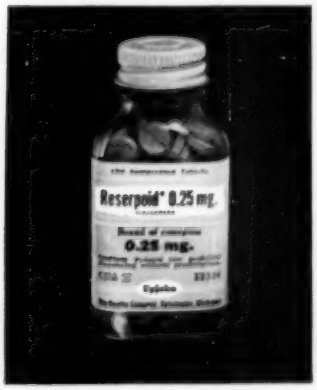

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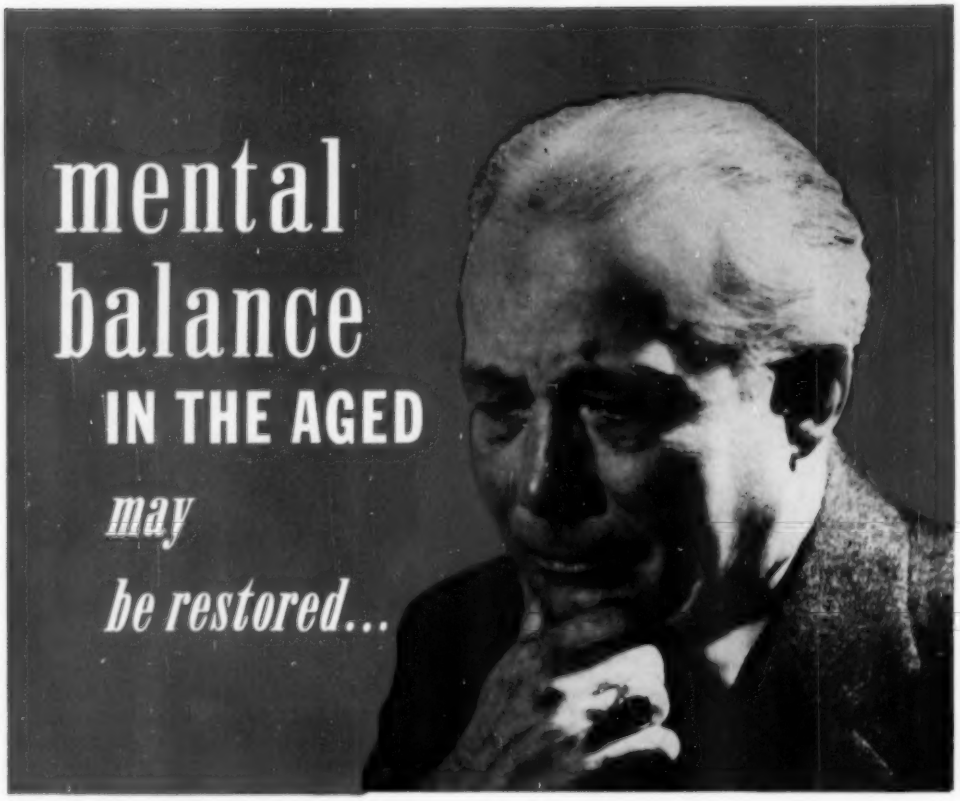

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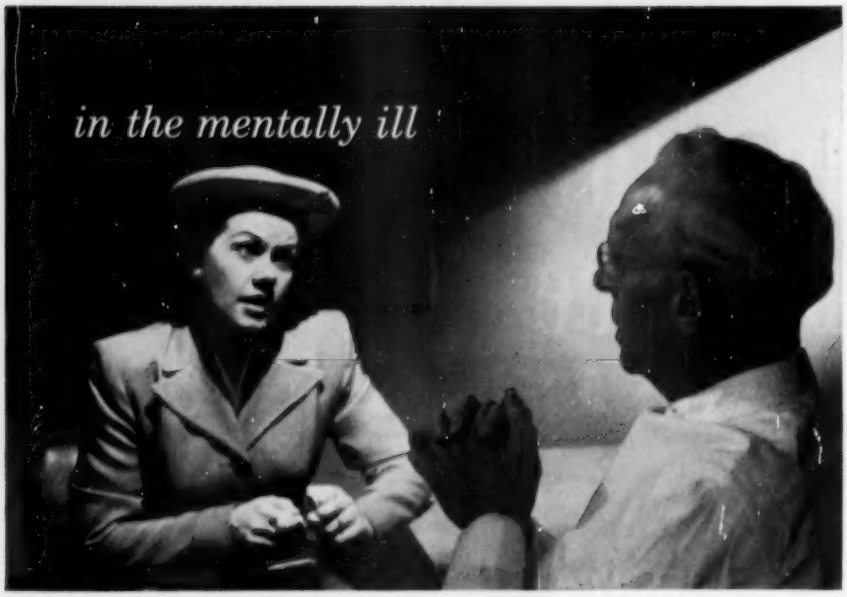

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COURSE AND OUTCOME OF SCHIZOPHRENIA [1]

F. A. FREYHAN, M.D., FARNHURST, DEL.

It becomes increasingly difficult to evaluate prognostic and therapeutic aspects of schizophrenia. This is due to the specialization of psychiatrists who have different concepts, work with different therapeutic techniques, and gain their clinical experiences with dissimilar patients. Greater uniformity of clinical management prevailed prior to the introduction of somatic and psychological therapies in the last 2 decades. Since then it has become apparent that there is more randomness in schizophrenic patients admitted to public hospitals than in patients often carefully selected by private or teaching hospitals on the basis of their fitness for particular therapies. Dissimilarity in onset, personality, and background devaluates the significance of schizophrenia as an identifying denominator for the purpose of comparative studies of outcome. How could it be otherwise with regard to an illness from which some patients, once hospitalized, recover without subsequent impairment while others enter a hospital to remain there the rest of their lives. Recognition of the incongruity and incompatability of clinical samples enables us to understand some of the controversies about conflicting claims on therapeutic statistics.

It is the purpose of this study to gather some facts about the course and outcome of schizophrenia in Delaware. The setting has the advantage of what we may call the 3 dramatic unities: of action, of time and place. There is but one psychiatric hospital in the small state of Delaware. This reduces to a minimum the number of administrative and social variables and provides a maximum of clinical uniformity which few, if any, hospitals in this country can equal. Moreover, the hospital has been under the directorship of Dr. Tarumianz for over 35 years. The writer has continuous personal knowledge of all schizophrenic patients in this study since 1940.

The present report is a summary of findings which will be dealt with in detail in a subsequent publication. The investigation, still in progress, was motivated by 2 questions which are recurrent themes in research on schizophrenia: (1) what is the natural course of this disease?, and (2) how have modern therapies affected this course? To find some answers to the first question, I studied the developments up to the present of 100 schizophrenic patients admitted consecutively since January 1, 1920. It should be stressed that these patients by virtue of hospitalization were exposed to influences on the so-called natural course of the disease. In a relative sense, however, they are undoubtedly closer to such a course than patients subjected to intervention by specific therapies. The 1920 group can, therefore, serve the purpose of a control against 100 schizophrenic patients admitted consecutively since January 1, 1940. The latter group had the benefit of therapies unknown in 1920.

We shall not make the error of seeing both groups as equally constituted. There are many differences of chance. There are inadequacies in the quality of information. Furthermore, we cannot ignore differences of social attitudes toward mental illness which may have played a part with regard to hospitalization. But for all these noncomparable aspects, the groups have strong elements in common. In 1920 as in 1940, patients were admitted without selection. They were exposed to the same clinical and therapeutic management then prevailing. Almost all who got well but relapsed returned to this hospital. Those who became chronically ill have been under continuous observation for the entire time of illness. (For statistical purposes, "present status" refers to December 15, 1953.)

No effort was made to distinguish between diagnostic types. Already Kraepelin found that:

> Delimitation of the different clinical pictures can only be accomplished artificially. There is certainly a whole series of phases which frequently return, but between them there are such numerous transi-

[1] Read at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

tions that in spite of all efforts it appears impossible at present to delimit them sharply and to assign each case without objection to a definite form.

The temporary predominance of catatonic, paranoid, or hebephrenic features leads frequently to diagnostic coercion and creates continuous disagreements among psychiatrists. Furthermore, progression of illness changes the clinical picture and necessitates repeated modifications of type diagnoses.

The Samples: Their Present Status

The 1920 sample consists of 51 male and 49 female patients. The 1940 sample consists of 50 male and 50 female patients. Their admission ages are shown in Fig. 1. In Table 1, for reasons of comparison, the 1920 sample is shown after 13 years—this being the time span of observation for the 1940 sample—

TABLE 1

Comparison of Present Status of 1920 and 1940 Samples

	D.S.H.*	Out †	Dead
1920	44	27	29
1920 as of 1933	65	24	11
1940	42	54	4

* D.S.H.—Delaware State Hospital.
† Out—separated.

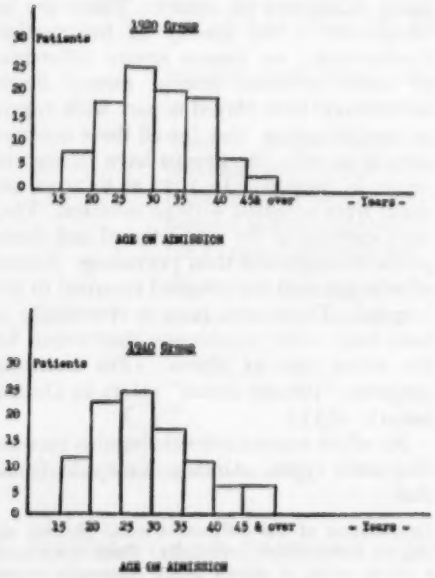

Fig. 1.—Schizophrenia.

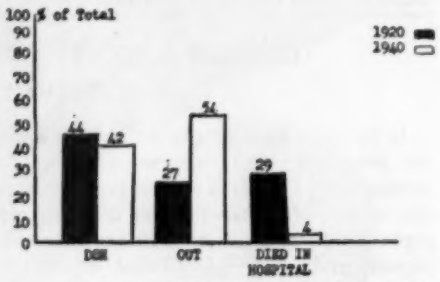

Fig. 2.—Status—December 15, 1953—Schizophrenia.

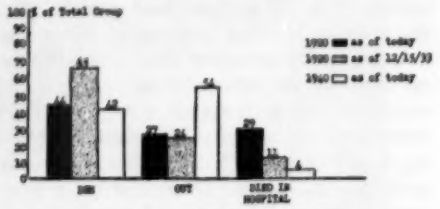

Fig. 3.—Schizophrenia.

as well as after 33 years. Information regarding their present status is illustrated in Figs. 2 and 3.

These findings indicate a drastic increase of separations since 1940. We also note a substantial loss of 1920 patients due to death. If we compare the 1920 status after 13 years with that of today, we recognize further mortality as the main difference since only 3 patients left the hospital subsequently.

What has been the fate of those who are still hospitalized? Their present situation can be characterized according to 3 social levels: (1) patients who are regular hospital workers and live the modestly normal hospital life with its absence of competitive and social demands; (2) patients who have maintained a limited capacity for interpersonal relationships but need to live on the wards; and (3) patients who have deteriorated to the level of complete isolation, untidiness and indifference (Table 2).

TABLE 2

Present Situation of Samples According to Social Level

	Working	Ward	Deteriorated	Total
1920	9	18	17	44
1940	10	21	11	42

The difference in time passed since onset of illness may account for the greater number of deteriorated cases in the 1920 sample. Generally speaking, there is little that these patients have in common clinically except the chronicity of their psychoses.

MORTALITY

It would seem that mortality has decreased if both groups are compared at the 13-year level. This may be explained by the fact that the majority of patients of the 1920 group, who died within a few years of hospitalization, died of tuberculosis. Generally, there is little evidence of relationship between mental illness and cause of death. Fifteen patients died of cardiovascular diseases, 7 died of tuberculosis, 7 of neoplasm, the rest of other causes.

At the time of death, 10 patients were deteriorated, 13 were better-ward patients, and 6 were hospital workers.

SINGLE AND MULTIPLE ADMISSIONS

In a gross sense, all schizophrenic persons admitted to hospitals can be arranged according to 2 classes and 4 types of outcome: (1) single admissions—(a) leaving the hospital, never to return and (b) staying in the hospital, never to leave; and (2) multiple admissions, eventually taking a favorable or unfavorable course. The outcome, according to this arrangement, is illustrated in Fig. 4.

Patients with multiple admissions do not constitute a clinical entity. Among them are patients who showed excellent improvements and returned to their pre-illness level as well as those mildly improved, but returned to hospital because of some social changes or difficulties in their environments. For the greater part, however, multiple admissions reflect on the capacity for compensation and decompensation of schizophrenic patients. Table 3 is an activity-index of the movements of those patients of 1920 and 1940 whose initial course appeared more favorable. We notice here a good deal of movement-activity in the 1920 sample. This is highly significant since it demonstrates that nearly half of the patients who became eventually chronic manifested an initial capacity for improvement. This holds true also, only more impressively

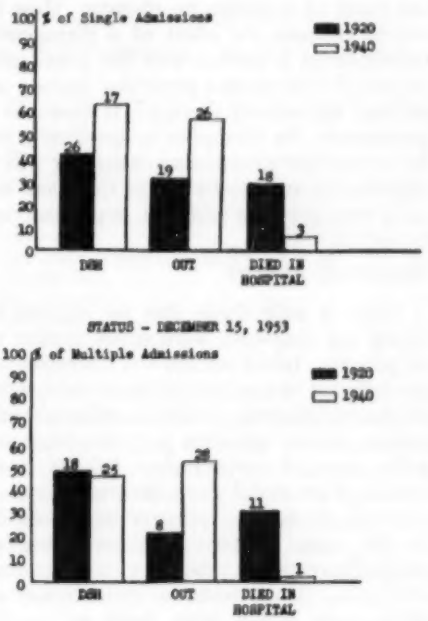

FIG. 4.—Schizophrenia.

so, for the 1940 sample. Here, more than 50% of the patients who now constitute the chronic group, responded favorably at first.

These facts clearly reveal the impossibility of establishing dependable prognostic criteria. We do not know on first admission whether the patient will return if separated; and if he returns we again cannot predict the further course. The concentration of schizophrenic psychoses in one hospital in Delaware has enabled me to recognize the important implications of the multiple admission group. While hospital statistics classify these patients as readmissions, there is insufficient reference to this group in clinical studies. This is regrettable because it impairs

TABLE 3

ACTIVITY INDEX OF PATIENTS WITH FAVORABLE INITIAL COURSE

	Frequency of admissions: 2	3	4	5	6-9	Total
	Number of patients					
1920	19	11	3	3	1	37
1940	21	17	6	4	6	54

the value of statistics on therapy. How is one to evaluate the effect of a therapeutic technique on a patient who has previously improved without this particular therapy or perhaps without any therapy? It should be a prerequisite for therapists to specifically refer to multiple admissions in a manner which explains the superiority of the treatment results over previous states of improvements.

DIAGNOSTIC ASPECTS

There is little doubt that the manner in which the diagnoses were made applies to all patients. Initial caution and discrepancies are reflected in a number of cases which were diagnosed differently before the schizophrenic nature became apparent and the diagnoses were changed accordingly. In the 1920 sample, these initial diagnoses were: psychoneurosis, 1; manic-depressive psychoses, 8; in the 1940 sample; psychoneuroses, 4; manic-depressive psychoses, 5; without psychosis, 1. A retrospective examination of these cases leaves little doubt as to the presence of schizophrenic psychopathology at the onset. This is not altogether *post hoc* reasoning in view of the fact that the initial diagnoses were often tentative but not reviewed subsequently, or were made on the basis of insufficient observations when patients left the hospital prematurely but returned later after progression of illness. Three of the psychoneurotic cases have since developed malignant hebephrenic patterns. On careful analysis of their initial complaints, however, we do not find psychoneuroses but the pseudoneurotic syndromes as described by Paul Hoch.

ONSET VARIETIES

The relationship between onset of illness and outcome has long been a matter of prognostic interest and etiological speculation. No sharp lines can be drawn, of course, and observations are often inaccurate and misleading. Nevertheless, we can distinguish between gradual personality changes and rather sudden transitions from social existence into psychotic states. The type of onset has fundamental bearing on the relationship of personality structure and psychosis. Conceptual differences pertain to the onset varieties. If we cut across the boundaries of various theories, we can reduce some of the differences to two basic versions: psychosis as a process and psychosis as hypertrophy of a personality type. Among many others, Sullivan(4), and more recently Bellak(2), discussed the justification for a nosologic dissolution of schizophrenia on the basis of onset and outcome varieties.

TABLE 4

OUTCOME ACCORDING TO ONSET

	D.S.H.	Out
1920:		
Sudden	46%	54% of total with sudden onset
Gradual	76%	24% of total with gradual onset
1940:		
Sudden	29%	71% of total with sudden onset
Gradual	51%	49% of total with gradual onset

The data here presented (Table 4) are fair approximations at best and are far more reliable for the 1940 sample.

As with many other characteristics, the significance of these data in relation to prognosis is dubious since we are not dealing with informative correlations. For example, the distribution of gradual onsets in the 1940 sample is practically identical in groups with favorable and unfavorable outcome, whereas strong predominance of acute onsets is associated with favorable outcome. If we turn from predictive to postdictive interpretations, it still remains obscure why some patients with sudden onsets fail to get better while others with gradual onset do. Obviously, the prognostic value of the onset varieties, though considerable, is limited in general application.

PERSONALITY AND FAMILY BACKGROUND

A similar difficulty arises with regard to the prognostic significance of the prepsychotic personality. If we include the various characteristics commonly associated with "schizoid personality", we obtain this distribution:

TABLE 5

	D.S.H.	Out
1920.....	74%	26% of total of schizoid type
1940.....	47%	53% of total of schizoid type

It is evident that patients with conspicuous prepsychotic personalities are more frequently those with unfavorable outcome but that this is not exclusively so is shown in the presented data. Generally, very little information can be gained by tabulation of traits since the patient's capacity for compensation must be judged against the background of his pre-illness way of life.

The family matrix deserves special mention since the majority of psychotic relatives were or are also patients in the D.S.H. While no details can be given in this summary, the following facts highlight the unique concentration of families in one hospital, characteristic for Delaware. In the 1920 group, 18 patients are related to 31 patients in the D.S.H., while in the 1940 group, 21 patients have 35 relatives in the hospital. Among these cases we find the majority of relatives to be parents, children, and siblings. The number of relatives to one patient, all in the same hospital, varies from 1 to 6. While only general prognostic conclusions can be associated with family incidence of psychoses, certain elements of psychopathology can be identified as dominant themes in many of these families, as has been described by Manfred Bleuler.

THERAPEUTIC ASPECTS

The patients admitted since 1940 had the benefit of specific therapies as well as of modern management. In addition to convulsive therapy, insulin coma therapy, and psychosurgery, there were, compared with 1920, intensified social activities, closer contacts with trained personnel, and more psychotherapy. Table 6 gives a presentation of somatic therapies.

An interpretation of the results must be made in the awareness that they tell only one chapter of a story, namely the status of each patient on December 15, 1953. The immediate responses, improvements or failures, are consequently not apparent. Eighty patients of the 1940 group had one or more of the somatic therapies. We see that the majority of the patients who had convulsive and insulin therapy had a favorable outcome. This holds true also for the group of 20 who presumably had no treatments. Of 16 patients who underwent psychosurgery, only 4 left the hospital. It must be kept in mind, however, that only those patients were selected for surgery who had failed to respond to other treatments and were no longer in an acute state of illness. Very little can be said with regard to each type of therapy since the distribution in this particular group of 100 patients is uneven. The low frequency of insulin coma treatment is due to the shortage of trained personnel during the war years. We see that 11 patients of the 1920 group had treatments after they had been in the hospital for over 20 years. These figures may seem very low, and they are not representative for the management of chronic schizophrenic patients in general. In most of these cases, however, there was little need for these therapies since the patients had made the type of adaptation which cannot be influenced or should not be tampered with. The results with psychosurgery on chronic patients have been reported previously and cannot be related to this sample.

TABLE 6

SCHIZOPHRENIA: SOMATIC THERAPIES

1920 Group

Treatment	D.S.H.	Out	Dead	Total
Convulsive	7	1	1	9
Surgery	—	1	—	1
Combination	—	—	1	1

1940 Group

Treatment	D.S.H.	Out	Dead	Total
Convulsive (Metrazol, ECT)	33	40	2	75
Insulin coma	4	6	1	11
Psychosurgery	12	4	0	16
Combinations	12	7	1	20
0	7	11	2	20

A further improvement can be seen in the decrease of time spent in the hospital by patients now separated from the hospital. A tabulation of total time spent in the hospital for both single and multiple admissions shows:

1920

S .....3 years—11 months—22 days
M .....5 years— 3 months—23 days

1940

S .....2 years—8 months— 6 days
M .....3 years—7 months—11 days

We shall not deal with the present status of the separated patients since the information is not complete at this time. Furthermore, no attempt will be made to distinguish

between degrees of improvement at the time of separation. The application of rating scales adds to the difficulties of evaluation without the provision of a tangible benefit. For long-term studies there is no advantage in categorizing behavioral items since the decisive criterion must be the capacity for social living. Experience has shown that patients, with few exceptions—and there will always be exceptions—remain outside the hospital as long as they appear improved in the environment from which they came. It would be puristic to cling to principles of insight or ideals of *restitutio ad integrum* as if the patient were an entity to himself, living in a vacuum. The patient's reintegrative capacity can be judged only against the background of what constitutes his world, his situation, his partners, and people. The number of multiple admissions provides a measure of the sensitivity of the environment's attitude: anxious to return him to the hospital when he is worse, but desirous to take him back as soon as he improves. Such a general view is admittedly of no value to experimental designs, but proves to be useful for this purpose.

Comments

The summarized findings reveal some facts about life and death of 200 schizophrenic patients. We followed their movements since 1920 and 1940 in order to make some comparisons. It is impressive to find that rate and speed of movement of the 1940 patients have more than doubled. Separation in both groups occurred for the majority within the first 2 years of hospitalization. This implies a fair degree of recovered social stability. But whereas we can summarize certain data in tables and statistics, we are on less factual grounds with regard to their implications.

It would be tempting to conclude that the better results reflect *eo ipso* on the effectiveness of new therapies. While there is evidence of this, our findings also suggest what has often been stressed by others: that the patients who respond favorably may be those destined for a more benign course of illness. The complexity of this problem becomes apparent when we analyze not only the successes but the failures. If we exclude the patients who died, we find that 40-45% of both groups have developed the malignant pattern of chronicity. Whether we find the ratio of favorable/unfavorable responses high or low depends a great deal on our knowledge of schizophrenia. It has recently been the trend to emphasize greater confidence in the recoverability of schizophrenic patients and to condemn the fatalistic outlook of yesterday. Most of the favorable results have consequently been attributed to newer concepts and therapies. Eugen Bleuler (1) stated in the beginning of this century that schizophrenia "can stop or retrograde at any stage." He reported about 515 patients treated in the Burghoelzli Hospital between 1898 and 1905 as follows: 60% of the patients had regained the ability to support themselves outside the hospital and to carry on their vocation, 22% had become severely deteriorated and 18% were intermediary types classified as "medium deterioration." Thus, only 40% of all admissions manifested a more severe trend from the outset. As is well known, Bleuler believed in early release in order to combat the psychological stagnation produced by the security and monotony of hospital life. He was convinced that

> . . . the therapy of schizophrenia is one of the most rewarding for the physician who does not ascribe the results of the natural healing processes of psychosis to his own intervention.

If we project Bleuler's findings and philosophy in the present, we must find it difficult to define the essence of progress in current results. Is it possible, for example, that an overconservative hospital policy delayed separation of patients and that modern therapies, independently of their specific effects on the patients, produced a change of attitude on the physician's part? The polypragmatic climate of today may very well have brought about a greater willingness to send patients home "since they had treatments." This could account for the faster tempo of movement found in recent results. It seems, furthermore, justified to assume that course and prognosis are favorably influenced by the speed of re-socialization which somatic and psychological therapies facilitate through rapid reduction or removal of disturbing symptoms that disorganize the inner continuity of the schizophrenic individual.

It has been postulated that deterioration is the result of therapeutic neglect. The 1940 patients had the opportunities for therapy and social rehabilitation. Of the 42 patients who became chronic, only 17 remained hospitalized continuously, whereas 25 improved sufficiently to leave the hospital for various intervals. The greater majority of these patients were subjected to various changes designed to counteract environmental stagnation. They were exposed to a variety of therapists and were given individual attention. Some had psychotherapy individually, others in groups. Some could never be reached as they isolated themselves from the beginning.

Through my continuous contacts with all patients hospitalized since 1940, I have had the opportunity to search for situational and psychological factors which could only be brought to light in the course of time. But while important information was gained, the impression was formed that no theory, intra- or interpersonal, can explain deterioration with any measure of general validity. It is always possible, and shown by 3 patients of 1920, that social living can be resumed in spite of 20 or more years of stagnation. But while from time to time such cases are published in order to highlight the effectiveness of a therapeutic technique, somatic or psychological, there is as yet no evidence of a common denominator which could provide a therapeutic beachhead in the battle against chronicity.

What can be concluded? Many will argue that collective studies are pedestrian exercises in figures which cannot enlighten us on matters of individual dynamics or therapeutic needs. Because of the prevalence of this belief we find today a widespread reluctance to invest interest in researches which transcend the intimate realm of individualized case studies. But we need not be fearful of surrendering psychodynamic prerogatives when turning investigative attention from individual to generic aspects of schizophrenia. Both do not stand in opposition but form component parts of a total concept of schizophrenia.

We must always guard against the "fallacy of the interesting cases," the generalization of some promising discovery, "the biased sampling which arises when we concentrate our attention exclusively on the changes that develop in some interesting section of the total group"(5).

The reported findings gain in significance because they pertain to total groups rather than to selected sections. As such they represent much of the variety and variability of schizophrenia which must be taken into account on questions of the natural course and its modifiability.

Conclusions

1. Long-span observations of 2 samples of schizophrenic patients, 20 years apart, in a setting of comparative uniformity disclose duplication of hospital separations since 1940.

2. Modern clinical management accounts for this significant improvement.

3. The beneficial impact of specific therapies appears inseparable from compensatory capacities possessed by favorably responding patients.

4. The malignant pattern of chronicity could not be reliably predicted on grounds of onset or personality nor averted by therapeutic efforts.

5. The summing-up of continuous observations and the analyses of factual developments are indispensable to our knowledge of schizophrenia and to an ascertainment of progress with therapies.

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DISCUSSION

Alfred Stanton, M. D., (Wellesley Hills, Mass.).—It is good to know that the coherence of the patient population which Dr. Freyhan describes is being used for observation of many of the puzzling developments in hospital psychiatry during the past few decades. His paper gives evidence that 30% more of the schizophrenic patients admitted in 1940

were outside the hospital and in better condition than of those admitted in 1920. Dr. Freyhan did not have space to give the statistical details which would indicate how probable it is that this difference occurred from chance, to correct all his tables to the comparable period of 13 years, or to show how the prognostic criteria were matched between the 2 groups; I shall assume that the differences are significant in what I say. It is an entirely plausible finding, and similar observations have been made at the Boston Psychopathic Hospital by Bockoven, and in a most careful study by Morton Kramer at the National Institute of Mental Health.

It is a finding of the greatest importance for those of us who work in mental hospitals. Deutsch suggests that in the middle of the last century discharges of patients in hospitals reached 90% and higher—and apparently these figures cannot be entirely brushed aside. The prognosis fell toward the end of the century, with the erection of the larger hospitals whose purpose was to bring about such improvements on a mass basis, and with the substitution of custody as a standard of care for the earlier moral treatment. Speaking very broadly, the customary level of discharges of first admission patients seems to have reached a low point precisely in the 1920's when neurologizing psychiatry was in its heyday; when Sullivan reported over 80% discharges from his special ward at Sheppard and Enoch Pratt, the profession met his report with the belief that his patients were, as they put it, not really schizophrenics. Nevertheless, beginning about this time reported rates began to improve; although the many complexities in the statistical reports were indicated by Dr. Freyhan, it seems to me that there is little room for doubt any longer that a definite and quite general improvement has taken place. I remarked that this is a matter of greatest importance because it is just as possible for them to slip back again as they did before, unless this time we can identify the contributing factors.

Dr. Freyhan mentions the 4 common ways of dealing with the improvement of a schizophrenic patient. Let me enumerate them in my own language: (1) because of the natural history of the disease; (2) because of the polypragmatic therapeutic program and the therapeutic atmosphere (or its opposite, when deterioration is attributed to therapeutic neglect); (3) specific types of therapy; and (4) alteration of discharge policy, either because of differences in the physician's practice, or in the attitude of relatives.

The concept of the natural history of the disease is of course irrelevant to an appraisal of the difference between the 2 groups of patients. I should like to be more definite—there is little evidence that the concept of the natural history of a mental disorder is a useful one. Everyday evidence indicates that patients' "symptoms" and the depth and manifestations of illness vary depending upon the meaning to them of their symptoms and of intercurrent events; more generally, at least in many cases, it is proper to say that the meaning of the symptoms to the patient is a functional part of the symptom, or of the illness. To the extent that this is so, there is little more reason for thinking of a natural history of the disease than of a natural history of church membership. The fact that the meaning is itself a part of the illness differentiates mental illness from measles, where the concept has been useful. Surely Dr. Freyhan's own evidence supports this view; there are different courses of illness—none more natural or unnatural than any other. There may be typical courses, as there may be a typical period of time to spend in high school, but it should be handled in the same way. Indeed, Caudill and the Yale group have shown how actively and effectively patients indoctrinate each other in how to be a mental patient; it seems to me very probable that there is a social norm among patients in each hospital which suggests how long patients should expect to remain in the hospital, and that this norm is somewhat effective in influencing the actual length of time before discharge.

The effectiveness of the general milieu has not been documented by Dr. Freyhan's study, but I think it incorrect to say that there is no evidence; I think the evidence is inconclusive—but it does exist and is very hard to get. The differences between Galioni's 2 groups is one example, and only one, of evidence. And it seems to me that Dr. Freyhan is compelled by his own figures to the view that there is a difference; something was effective. I found about 62%-73% chronicity, if the deaths are ignored, in computing the 1920 group from Table 1. It is probably true that the patients who responded favorably were, as he puts it, those destined to do so, but the comparable patients in 1920 did not do so.

The evidence that one specific therapy or another has made a difference again does not come from this type of evidence. I think that in dealing with such problems, Dr. Freyhan would find that it was necessary to categorize patients at least somewhat—for there are different types of improvement. I know of no one who would identify the quieting effect of lobotomy with other types of change toward the social average which is usually called improvement. And those of us who have tried to appraise psychotherapy, with its long duration and difficulty in arranging controls, have found ourselves forced to rely upon ratings, at least primitive ones. To do otherwise is to equate recovery with discharge from the hospital.

The possible alteration of discharge policy is the most interesting problem from a methodological standpoint. It seems very clear that we cannot take the physician's judgment as a baseline however convenient it would be for the statistician. And this is the great problem with discharge rates as an index of hospital performance. They have long been thought of as the hardest of the various criteria (aside from, perhaps, the ability to remain gainfully employed), but they are nevertheless a function of the hospital in a curious way. They depend for many hospitals upon the rate of admission; when a patient is admitted, a patient is discharged, not right at the same time, but nearly so. This means that, where the hospital is full, it will often be true that the patient who is discharged is not the one who is himself "ready" for it, but the

one who is the nearest ready for it, and who can be discharged without much staff work. Studies of the effectiveness of social workers in the hospital show convincingly that they can often bring about the discharge of many patients who presumably would not be discharged otherwise—so the shortage of staff time in most hospitals (including some which are thought of as relatively wealthy ones) is a factor in the discharge of any patient. What I am trying to get at here is the fact that the mental hospital is an integrated system, and any item or event occurring in it, like the discharge of a patient, is a function of the whole system. Such a fact complicates the comparability of statistical studies from one hospital to another, or from one time to another in some cases, to such an extent that we can at best regard them as tentative indices until we know more about the institution which forms the setting within which our data originate.

F. A. FREYHAN (Farnhurst, Del.).—The concept of a natural course of schizophrenia should not be misconstrued to imply nosologic unity or to reflect teleological opinions. It refers simply to patterns of outcome which have been observed and reported for several decades. We need to know something about epidemiological findings and interpretations before we attempt to explain the effects of therapeutic endeavors—somatic, psychological, or social. The international literature indicates close similarities relative to frequency, course, and outcome which compel us to recognize certain generic aspects of schizophrenia.

I do not believe that we can change the data of the 1920 group by ignoring the deaths as has been suggested. The group must be taken as a whole and the question must remain open whether or not those who died might have improved mentally.

The comments on the importance of hospital attitudes and policies are very pertinent and helpful. The advantage, and what I believe to be the value, of this study should be seen in the relative constancy of observational opportunities which I have pointed out in detail. The anonymity and generality so often found in clinical-statistical reports from large institutions in bigger states necessitate rating scales to define varieties of improvement. The intimacy of conditions, on the other hand, which favored this inquiry, provides some answers to questions of the nature of improvement that seem more meaningful and informative than scales or tables.

TRACER IODINE STUDIES ON THYROID ACTIVITY AND THYROID RESPONSIVENESS IN SCHIZOPHRENIA [1, 2]

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This paper is a preliminary report on a proposed long-term study of thyroid activity in schizophrenia.

HISTORICAL BACKGROUND

Cases of disturbed thyroid function, whether hyper- or hypofunctional, often exhibit psychiatric symptoms(1). In particular, cases of hypothyroidism, often without myxedema, are frequently seen with a fairly well-developed paranoid delusional system. It is interesting to note that Bleuler described some rare cases of hypothyroidism scarcely distinguishable from schizophrenia(2). From time to time, success has been claimed in treating schizophrenia by the administration of thyroid extract or thyroxine(3). With regard to the administration of thyroid hormone to schizophrenics, it is interesting that many who have tried this therapy have reported the unexpected finding of an apparent hyporesponsiveness of schizophrenics to thyroid hormone whether given orally or parenterally. Among other prominent investigators, Hoskins(4) has noted this phenomenon. It is not implied, however, that this finding has been universal. There have been occasional reports of apparently healthy individuals displaying hyporesponsiveness to thyroid hormone. However, this phenomenon has been reported much less frequently in the normal population than in schizophrenics. Among schizophrenics, the catatonic group seems particularly liable to this hyporesponsiveness. Bowman(5) in 1925 presented evidence of a significant lowering of basal metabolic rate in schizophrenics, taken as a group and compared with a normal population. Paradoxically, in 1950, the same author demonstrated an apparently higher thyroid activity (as measured by thyroidal fractional uptake of tracer iodine) in schizophrenics compared with a normal population(6). Brody(7) made a study of serum protein-bound iodine in psychiatric patients and in a normal group. His finding was that, while the schizophrenics had a higher mean serum protein-bound iodine than the normal mean, this difference was not statistically significant. It should be remembered, however, that straight biochemical estimation of serum protein-bound iodine is not sufficiently reliable to make differentiations in the order of one gamma iodine percent, and that techniques using radio iodine tracer have much higher reliability and sensitivity and may confer significance on small differences. Brody pointed out that, among his psychiatric patients, the incidence of high levels of "psychological tension" was greater in the patients who had a "high normal" serum protein-bound iodine than in those with a "low normal" serum protein-bound iodine.

OBJECTIVES OF THIS RESEARCH

The current short-term objectives of this research are: (1) estimation of thyroid activity in schizophrenic patients and in a normal control group, by measuring the fractional uptake of an I_{131} tracer dose in the thyroid gland 24 hours after the administra-

[1] Read at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

[2] The initial cost of equipment has been defrayed by grants-in-aid from: The National Institute of Mental Health (Grant No. M-509-MH) and The Grant Foundation. The 4-channel scintillation counter, used for gamma counting of I_{131} in the neck, was constructed from classified blueprints released on application for this project by the Atomic Energy Commission. The 4-channel scintillation counter had first been developed in a joint project by the research department of the Beth Israel Hospital at Boston and the nuclear research department of the Massachusetts Institute of Technology. The blueprints subsequently became the possession of the Atomic Energy Commission.

[3] Senior research scientist, Research Facility, Orangeburg, N. Y., and research assistant, department of Neurology, College of Physicians and Surgeons, Columbia University; Rockland State Hospital; formerly research scientist and director of laboratories, Research Service, Worcester State Hospital, Worcester, Mass.

[4] The author is grateful to Mr. Nathaniel Griffin for his assistance and numerous fruitful suggestions during the Worcester phase of this project.

tion of this dose; (2) the incremental response in thyroid activity, again in terms of I_{131} neck uptake fractions, measured 48 hours after a 10 milligram intramuscular injection of thyroid stimulating hormone (T.S.H.) (Armour).[5] The incremental response for any particular subject is operationally expressed as the ratio of:

$$\text{the } \frac{\text{post T.S.H.}}{\text{pre-T.S.H.}} \text{ values.}$$

Experimental Design

PATIENTS

Thirty-one chronically ill male schizophrenic patients, 22 from the research ward, Worcester State Hospital, and 9 from the Research Facility ward, Rockland State Hospital, are reported. Prior to the beginning of the experiments, the Worcester group had been continuously under supervision and investigation for 3 years, while the Rockland group had been under the same kind of supervision for only 6 months, by the respective research departments of these 2 hospitals.

Age.—The age in the Worcester group varies from 23 to 57 years, 4 of the patients being over 40. In the Rockland group, the range is from 30 to 40 years.

Diagnosis.—The question of diagnosis was settled in an operational manner: (1) the patients had been diagnosed as "schizophrenics" by the general hospital staff of the respective hospital; and (2) there was unanimous agreement by the 5 psychiatrists present on the research staffs of the respective hospitals that each patient was properly diagnosed "schizophrenic." Three of these psychiatrists were first on the research staff at Worcester State Hospital and moved later to the Research Facility of the Rockland State Hospital, thus ensuring some diagnostic continuity. In each hospital there was available a large group of patients for selection. They were chosen in accordance with a set of criteria described elsewhere(8), some of which are listed below.

Length of Continuous Hospitalization.—The Worcester patients had been continuously hospitalized there from 3 to 17 years. The Rockland patients had all been continuously hospitalized for at least 10 years in that hospital.

Physical Normality.—The possibility that the patients might have been suffering from mild and/or chronic nonrecognized physical disorder was decided mainly by the following 3 criteria: (1) a record of maintained good health while the subject was under continuous supervision in the research ward of the respective hospital; (2) physical examination with negative findings before the beginning of the experiment; (3) negative laboratory findings as were required in specific instances or as may have been done as part of other research projects. We had, naturally, greater confidence in the organic normality of the Worcester patients, since they had been much longer under our care, and had at the same time, in connection with other projects, been subjected to a very considerable joint investigation by the Worcester Foundation for Experimental Biology and the research department of the Worcester State Hospital. Such laboratory indices as: red cell counts, white cell counts, sedimentation rates, serum cholesterol determinations, and others had been frequently estimated right up to the beginning of this project. The Rockland patients had been under our care for 6 months at the time the experiment began. They were selected from some 8,000 patients from the chronic wards of the hospital. The Rockland group originally numbered 15, but, subsequent to the completion of the experiment, 6 were excluded as the presence of low-grade or latent chronic disorders and infections, unsuspected or unproven until then, was confirmed. Data on those 6 patients will be found in the appendix.

Nutrition and Diet.—No attempt was made to equate individual patient's "nutrition" to operationally preset limits; however, all patients looked well and ate well. Their food was of good quality, sufficient quantity, and was palatable (personal experience). Although no formal analysis was made of the diet, all patients received vitamin supplements daily and the hospital dietitians confirmed that the diets were adequate in caloric value, mineral and vitamin content, and in the balance of the main constituents. In particular, no formal analysis of the amount of

[5] Appreciation is expressed to the Armour Laboratories, Chicago, Ill., for the supply of T.S.H.

iodine in the diet was made in the case of the Worcester group, but this investigation is part of the program in the project at Rockland. Another uninvestigated question in both instances (but on the program for investigation at Rockland State Hospital) is the possibility that there may be significantly different amounts of antithyroid substances of vegetable origin in the diet of hospital patients compared with the average diet of the normal controls. The antithyroid substances referred to are found especially in members of the *brassica* (cabbage) family.

Intra-experimental Control.—Variables such as environmental temperature, severe anxiety, physical fatigue, etc. are known to influence thyroid activity in a relatively short time. With respect to temperature, the patients in both research wards were subjected to a rather constant environmental temperature compared with that experienced by the normal controls. My impression is that this temperature was constantly higher, winter and summer, and would at times have been reckoned uncomfortably warm by the normal controls. Fatigue of physical origin never appeared in any of the patients in this group. "Anxiety," that bug-bear of all such research as this, was recorded nonquantitatively, on the basis of clinical impression and prior knowledge of the patient. No attempt was made to rate it quantitatively. However, an attempt was made, in both hospital groups, to minimize any additional anxieties which might accrue from the carrying out of the experiment itself. This was done by having a number of "dry runs," during which the patients went through the whole ritual of having the experiment outlined by the investigator, of sitting in turn for a minute or two in the chair between the 4 channels, seeing the scaler operate and afterwards drinking their potions of dummy radio-iodine. It appeared to this investigator, and to members of the nursing staff, that although a number of the patients showed anxiety, apprehension, or resentment when the experiment began, by the third "dry-run," no patient exhibited any overt evidence of these emotions. Those patients who were curious to know what was being measured were told the truth, but the facts were limited to the questions that were asked. A few insisted on more complete information, and these were frankly told that they had radiation in their necks, as a consequence of the drinks that they had taken. They were permitted, if they wished, to examine the equipment, watch it in operation, and discuss the process. A fair example of how the experimental procedure became apparently benign to the patients is illustrated below.

One evening in Worcester, when neck counts were being taken, one patient was left in the toilet while the rest of his group had their neck counts. He appeared a little later, in tears, because he thought he was to be denied his daily scientific ritual.

CONTROLS

Thirty-five apparently normal male control subjects underwent measurement of the 24-hour fractional uptake of an I_{131} tracer dose in the neck. Of these 35, 28 further underwent the measurement of their incremental response following T.S.H. With regard to the criteria used in selecting the normal control group, after admitting the single greatest loss of control—that the normals do not live chronically in a mental hospital ward—an attempt was made to match, as closely as possible, the criteria employed for the patients. The ages of the normal control groups ranged from 20 to 52 years. The "nutrition" of these normal subjects appeared good. Nearly all of them worked in the hospital as attendants, office staff, garage hands, truckdrivers, etc. They were thus not completely unknown, and one had some idea of the stability of their health record. None presented any history of thyroid disorder, nor severe psychiatric disturbance. None was accepted who was, at or near the time of estimation, under severe emotional stress, or who had recently recovered from an illness. No attempt was made to limit the diet; they were, however, told not to eat any lobster or crab or take any medication with iodines for a week preceding the experiment. The same test procedure was followed as with the patients save that the normal controls were not subjected to any "dry runs."

Reactions to T.S.H.—Following the 10-milligram intramuscular dose of T.S.H., no significant psychiatric changes, local irritations, nor symptoms of protein hypersensitivity have been noted in either group to date.

On interrogation most of the normal controls complained of a transitory localized pain "like a bee sting" in the injection site.

SPECIAL APPARATUS

The measurement of I_{131} neck uptake is a commonplace in large hospitals nowadays, but the use of a multichannel counter is sufficiently unusual at present, and offers so many advantages, especially in measurements of psychiatric subjects, that some description of the equipment is in order. The 4 scintillation heads are symmetrically spaced throughout a 360° horizontal plane. It can be shown theoretically, and demonstrated practically, that there exists within the 4 channels a "free circle" wherein the alteration in the gamma count of a point source of I_{131}, as it is moved from the center to the periphery of this "free circle," is well below the standard error of the estimation of the activity present in the neck. Those interested further should consult the literature(9). The diameter of the "free circle" can be varied considerably by movement of the scintillation heads within the protecting lead shields. This investigator, at present, sets the 4 heads so as to constitute in the horizontal plane a "free circle" of some 20 inches diameter, and in the vertical plane a "free circle" of some 10 inches diameter. In practice, this has permitted reliable thyroid measurement in patients who are restless, shout, sing, read, or sit on the edge of the chair for a quick getaway, etc. Thus, the patient is not under any possible extra tension imposed by the estimation procedure. This is in contrast with measurements with a single-channel system, where the subject has to keep his head very steady and rigid, or have it kept so in a head clamp.

It will be recalled that the intensity of gamma radiation decreases with the square of the distance. With a single channel this is an important and limiting aspect of measurement, whereas inside the "free circle" of a multi-channel system, the loss of intensity by movement away from any one channel is compensated for by the gain of intensity in the channel opposite. When gamma counting of very small tracer doses in the neck is undertaken, an important correction termed "neck scatter" is necessary. In explanation, it will be said here only that this "neck scatter" is a pseudoincrease in count of the radioactive tracer in the neck due to secondary gamma emission due to the partial absorption of the primary gamma radiation by neck tissues. Some of this secondary radiation is intense enough, when the radio isotope detector is close, to be recorded along with the primary radiation, leading to a spurious increase in count. Now, with a single-channel system, even with a cooperative patient, it is difficult to assess the requisite correction for this error. Instead, the usual practice is to place the patient at a distance sufficiently far from the face of the radio isotope detector that secondary radiation becomes too attenuated to be picked up. The obvious great disadvantage here is the increased distance of the detector from the source, resulting in very large loss of sensitivity, and the patient must necessarily be given a much larger dose of I_{131} to obtain significant counting rates in the neck. With a 4-channel system one can gain a fairly representative 360° "look" at this pseudocount increase and by means of a simple device make suitable correction for it. The simultaneous 4-sample pick up by the symmetrically arranged scintillation heads results in a sensitivity which is a little better than 4 times that of a single channel. Since "neck scatter" correction is simple and valid, it is not necessary to move the detectors away from secondary radiation, thus conserving sensitivity. These and other special advantages allow for a great reduction in the size of the tracer I_{131} dose. The small dose is particularly important in such a project as this, wherein a long follow-through of the same subjects with frequent testings of thyroid function is envisaged, and one wishes to take every care to minimize the possibility (even though probably remote) of even temporary damage to the thyroid epithelial elements. Thus, this investigator uses, satisfactorily, as his maximum oral tracer dose, 5 microcuries of I_{131} for thyroid uptake determinations. If necessary, it is possible to measure thyroid uptake at 24 hours using only 1 microcurie as oral tracer dose. The only difference is that a considerably longer time is required for accumulation of the number of counts for the statistical reliability required. This dose is probably one of the

smallest oral tracer doses administered currently for clinical determinations. The successful use of a 1 microcurie oral dose implies that the detector is sensitive enough to measure with accuracy and reliability approximately a ¼ microcurie of I_{131} in the thyroid gland.

Briefly, the rest of the apparatus consists of (1) an integrator control box, wherein the 4 separate incoming signals from the scintillation channels are independently switched and independently regulated for sensitivity, so that the necessary counting balance can be obtained ensuring a "free circle." I shall not describe the electronic circuits used in the scintillation heads, the data concerning sodium iodine crystals used as phosphers, or the photomultiplier tubes used, etc. The pulses received at the integrator control box are fed either into the linear amplifier input, or the discriminator input strip of (2) a #1070A Atomic Instrument Company Multiscaler. In this instrument the incoming impulses are discriminated to a desired pulse height threshold through a manually controlled Schmitt discriminator circuit, and the pulses are then recorded in the usual way on a series of decade strips. For those who are interested technically, a few basic performance data may be interesting. The pulse-height discriminator is usually set from -6 to -8 volts and the high voltage to the photomultipliers at from 1,000 to 1,500 volts. With all 4 channels operating in balance, the background usually ranges from 400 to 500 per minute; the sensitivity varies from 1,250 to 1,500 counts per microcurie per minute. The signal to background ratio per microcurie of I_{131} ranges from 2 to 1, to 3.75 to 1.

Special Materials.—Radioactive iodine, I_{131}, is obtained from the Atomic Energy Commission and is administered orally in the form of sterile sodium iodine solution. No carrier is used.

Thyroid stimulating hormone, "T.S.H.", has been generously supplied for this project by Armour & Co. It probably contains minute amounts of pituitrin and protein break-down substances together with moderate amounts of gonadotrophic hormones. It is said to be free from A.C.T.H.

TECHNIQUE AND MEASUREMENT

The pretest procedure for the patients and controls is restricted to ensuring that they have not had any iodine, thyroid, thyroxine, any other hormones, or any antithyroid drugs during the preceding month. It should be remembered that sometimes an overlooked source of iodine ingestion is an expectorant cough mixture. All control subjects having a cough not serious enough to invalidate them for the test are checked about the use of cough medicines. If such a specific is being taken, no determinations are made before it is certain that this medicine does not contain iodine. Another well-known trap is the recent administration of lipiodol or other iodine-containing radio-opaque substance. No test of iodine uptake can be carried out before such substances have been completely excreted from the body. As far as diet is concerned, the authorities to whom I have been able to refer usually counsel that it is sufficient to ensure that no lobster, crab, or seaweed have been eaten during the 3 days preceding the test.

Time of Administration.—Up to the present the practice has been to administer the tracer dose orally between 2:00 and 4:00 p.m., about 3 hours after the last meal. Before giving the pre-T.S.H. dose, an estimate of neck scatter is made for each subject, using the method described by Brownell(9).

Tracer Dose Administration.—The investigator himself draws up the individual doses with an accurate syringe pipette and watches each subject, whether patient or normal, swallow the dose. For each subject, or for each group of subjects measured simultaneously, an exact replica of the dose is introduced into a 100 cc. volumetric flask, made up to 100 cc. with distilled water, sealed with paraffin and labeled with the date, the subject's or group's name, and the time at which the dose was administered. This sample of tracer henceforth is referred to as the "standard dose."

Counting Procedure.—Twenty-four hours after swallowing the tracer iodine dose, the subject presents himself for a neck count. This count is, if practicable, made up to a total of 10,000. If the subject be otherwise inclined, a lesser count will be accepted, pro-

vided that it exceeds 2,000 counts in all. After the subject has left the room, his standard dose is then counted again for 10,000 counts. A current estimate of background (10,000 counts) completes the data necessary for neck uptake estimation. In all cases, the attempt has been made to follow the daily level of the I_{131} in the neck for at least 7 days after each phase of the experiment and thereafter at periods of twice a week until no counting rate significantly greater than background be recorded. Plotting these data on semi-logarithmic paper gives a reasonably straight-line representation of the rate of biological utilization of the new organically-bound fraction of the I_{131} taken up into the thyroid gland.

Part II of the Experiment.—At "zero" time the subject is given an intramuscular dose of 10 mg. of T.S.H. in 2 cc. of normal saline, preferably deep into the muscles of the buttock. If a subject has still residual activity from a previous dose of I_{131}, neck, standard dose, and background counts are taken as usual. The correction for the number of counts to be attributed to this residual activity on any later occasion may reliably be obtained by extrapolation along the curve of biological utilization for that individual. Twenty-four hours following the injection of the T.S.H., the subject receives a standard dose of radio iodine again, equal to the dose received in the first part of the experiment. At 48 hours after the T.S.H. injection, *i.e.*, 24 hours following the I_{131} tracer, the neck uptake fraction of the second tracer is measured, and, as before, the count is followed daily for 7 days and then twice weekly until such time as significant count rates can no longer be obtained.

Limits of Accuracy and Reliability of the Method.—As described above, amounts as small as a $\frac{1}{4}$ of a microcurie can be accurately and reliably estimated in the neck. As derived from the Poisson series mathematics, the standard deviation of any count is the square root of that count. Analyses carried out at frequent intervals on a typical experimental series in single subjects indicate that the final fractional neck uptake figure at 24 hours has a coefficient of variation of less than 1%.

FINDINGS

Only 17% of the controls register above 30% uptake (Table 1), while 62% of the patients are above that level. Only 1 patient (3%) registers below 25% uptake in 24 hours. The means for the hospital groups taken separately and for the hospital group in concert are very significantly different from the means for the normal group. These differences have "p" values far better than 0.001. The Rockland patients have a mean uptake 5.7% greater than the Worcester patients. This difference has a "p" value of 0.05. However, since the groups are relatively very small and unequal, little confidence will be placed in this "p" value of 0.05.

As indicated in Table 2, 54% of the normals have an uptake exceeding 50% in 24 hours while only 2 patients (6%) reach this figure. The means for the Worcester group and the combined hospital group are very significantly different from the mean of the normal group with a "p" value far better than 0.001. There is no significant difference between the normal group and the Rockland patient group, which may be accounted for by the small number of cases in the Rockland group, or it may be due to other factors.

TABLE 1

PER CENT UPTAKE I_{131} TRACER DOSE IN NECK AT 24 HOURS (PRE-T.S.H.)

Uptake	Subjects			
	Controls (35)	Worcester Patients (22)	Rockland Patients (9)	Total Patients (31)
	%	%	%	%
Above 30%	17	55	78	62
25-30%	34	41	22	35
Below 25%	49	4	0	3
Means	25.7	30.9	36.6	32.6
Standard deviations	6.25	3.97	7.18	5.59
Ranges	9.6-38.5	24.8-39.3	27.7-51.8	24.8-51.8

TABLE 2

PER CENT UPTAKE I_{131} TRACER DOSE IN NECK AT 24 HOURS (POST-T.S.H.)

Uptake	Subjects: Controls (28)	Worcester Patients (22)	Rockland Patients (9)	Total Patients (31)
	%	%	%	%
Above 50%	54	0	22	6
30-50%	36	82	78	81
Below 30%	10	18	0	13
Means	47.9	33.4	47.4	37.5
Standard deviations	12.15	7.19	8.99	9.88
Ranges	22.1-71.8	15.3-47.8	37.4-68.4	15.3-68.4

The ratios in Table 3 demonstrate the most striking difference between the normal subjects and controls. While 93% of the controls showed increase of activity of over 60% following T.S.H. injection, only one patient in the combined hospital group (3%) exceeds that figure. The remaining patients are all below 60% increase in activity. The means for separate hospital groups and the combined hospital group show extremely significant differences from the mean for the normal control group with "p" values far below 0.001. The Rockland patients' mean is 24.3% higher than the Worcester patients' mean, and this difference has a "p" value of 0.05. However, as explained above, little confidence will be placed in this "p" value.

There is a significant difference in the time taken by the patients to achieve maximum take up in comparison with the controls, both in the pre-T.S.H. and the post-T.S.H. phases of the experiment.

Pre-T.S.H. Phase.—All but 5 of the normals reached their maximum in the first 24 hours, while only 2 of the patients did so. The mean time of arrival at maximum for the patients was day three; 5 did not reach their maximum level until day five.

Post-T.S.H. Phase.—1. All the normals reached their maximum in the first 24 hours, all but 7 of the patients in the first 48.

2. There was a significant difference in the length of the biological half-life, *i.e.*, the time taken for half of the I_{131} stored as organic compound in the gland to be psysiologically utilized for the patients and the controls. The controls had an average figure of some 29 days, the patients an average of 52 days.

3. B. M. R. was measured in 10 of the Worcester patients. The mean measurement was -12%; the range from -29.8% to 9.7%.

4. There were no correlations of age with any of the indices mentioned above.

5. The Worcester patients are part of the total schizophrenic group upon which the Worcester Foundation for Experimental Biology carried out their research on adrenocortical response to ACTH and stress. This group was reported by them to show a significant hyporesponsiveness to ACTH. No joint figures on the individual Worcester pa-

TABLE 3

RATIO $\frac{\text{POST T.S.H.}}{\text{PRE T.S.H.}}$ UPTAKE AT 24 HOURS

Uptake	Subjects: Controls (28)	Worcester Patients (22)	Rockland Patients (9)	Total Patients (31)
	%	%	%	%
Above 160%	93	0	11	3
Below 160%	7	100	91	97
Means	185.1	109.2	133.1	116.6
Standard deviations	27.6	24.3	29.48	27.03
Ranges	116.2-259.6	61.7-151.9	72.2-169.3	61.7-169.3

tients have yet been prepared. These may be published later.

Discussion

The new and highly significant finding of this research is an apparent hyporesponsiveness to T.S.H. in schizophrenics as compared with the control group. In the compilation of data from which this conclusion is drawn, it is very interesting to note that 2 findings of Bowman are confirmed: (1) that there is a significantly higher thyroid activity (as measured by 24 hours fractional uptake of I_{131}) in the schizophrenics compared with that in the controls; and (2) that those patients in this series who were measured had a lowered B.M.R.

These findings are highly significant in the statistical sense but do not necessarily demonstrate an association or tendency in schizophrenics. First, a greater number of patients and controls must be tested. Secondly, it is necessary to exclude the possibility that the differences may be due to the different environments of normals and institutionalized schizophrenics. For example, the raised thyroid uptake might be not so much an expression of differing thyroid activity but possibly the result of a differentially lower amount of iodine in the diets of the patients relative to the controls. Or, the diet of the patients and the controls may contain chronically different concentrations of anti-thyroid substances of vegetable origin, such as have been described in the *brassica* (cabbage) family. It may be again that the higher and in general more constantly regulated environmental temperature of the schizophrenics may reduce the potential responsiveness of their thyroid glands.

Such possible factors as these are in the program of investigation at Rockland State Hospital. An obvious way of checking institutionalization factors is the comparison of the newly admitted, first admission schizophrenics with the chronically institutionalized patients. Another project to be carried out here is the comparison of thyroid function in the above schizophrenics with that in chronically hospitalized, psychiatric, nonschizophrenic patients.

Bearing these reservations in mind, I hesitate to speculate. Should, however, the above findings prove to be independent of environment, it may be necessary to raise such questions as: (1) Do schizophrenics respond less to T.S.H. as part of a general pattern of diminished endocrine response to pituitary trophic principles? (2) Is this hyporesponsiveness a peculiarity specific to the thyroid gland alone, or does it suggest that the schizophrenics might be (to borrow from Thoreau,) "living lives of quiet desperation"; existing in a manner such as to throw great and continuous stress on the thyroid gland—to develop thyroid "fatigue." Such "fatigue" could be accompanied by a diminished T.S.H. response and a lowered general tissue response to thyroid hormone itself, as instanced by lowered B.M.R. and absent or lowered physiological responses to the administered thyroid hormone. This vague concept is more clearly and certainly more precisely phrased by Shakespeare as, "He tires betimes who spurs too fast betimes."

Whatever the ultimate explanation, it is indeed interesting that the Worcester group, which showed so markedly reduced T.S.H. response, was drawn from that same total group of schizophrenics upon whom the study of adrenocortical response to ACTH was made by the Worcester Foundation for Experimental Biology. Hoagland, Pincus, *et al.* reported this group to be significantly hyporesponsive to ACTH compared with normal controls. The current program of another investigator at Rockland includes a parallel study of corticoadrenal function in the Rockland group of schizophrenics. The joint findings of hyporesponsiveness in both the thyroid and adrenocortex in the Worcester group are suggestive. Confirmation of such findings would lend support to the popular but still vague hypothesis that there exists in schizophrenics some central disorder of regulation of the endocrine system, though such disorder be not necessarily etiological.

Summary

1. Thyroid activity has been studied by measurement of 24 hours' fractional uptake of tracer dose of I_{131} in 31 schizophrenics and 35 normal subjects.

2. Following T.S.H. (10 mg.) intramuscular injection, there has been shown to exist

a highly significant difference in the normal subjects and the patients in the incremental response of thyroid uptake.

3. Bowman's findings of increased thyroid activity (as measured by I_{131} uptake) and of lowered B. M. R. in schizophrenics are confirmed here.

4. The possible role of environment is discussed and future studies are outlined.

Appendix

Six patients excluded from the Rockland project.

Name	Reason for exclusion
A	Diabetes mellitus
B	Fistula in ano with abscess formation
C	Amebiasis and recurrent lung infection
D	Persistently raised sedimentation rate and leucocytosis
E	
F	Lesion not yet diagnosed

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SOCIAL MOBILITY AND MENTAL ILLNESS[1, 2]

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This is a further report on the interdisciplinary research into social stratification and psychiatric disorders that has been underway in the New Haven community for the past 5 years. Previous papers have reported highly significant relationships between social class position and (1) the number of patients in treatment; (2) the types of disorders; and (3) the kinds of treatment received(5, 6, 7, 12, 13, 14, 17).

A basic hypothesis of this research postulated interrelationships between mobility in the class structure and mental illness. The idea that an individual's movement in the social structure is associated with the development of psychiatric difficulties has been expressed by both psychiatrists(4, 8, 11, 15, 16) and sociologists(10, 18, 19). Some empirical research has been done on the question in each field, but psychiatrists and sociologists have not worked together previously to determine if psychiatric patients are more or less mobile socially than a comparable group of nonpatients. The research reported here attempts to do this.

One of our general propositions under study hypothesized that in the several social classes interrelationships exist between mobility factors and diagnosed psychoneurosis and schizophrenia. Because of space limitations only 2 aspects of mobility, out of a much larger matrix that was used to test relevant facets of this proposition, will be reported here. They are: (1) achieved social mobility, and (2) discrepancies between an individual's achievement and his aspirations. A specific proposition on each factor was stated as follows: (1) There is a differential relationship between the amount of social mobility achieved by nonpatients in comparison with psychoneurotics and schizophrenics of the same class as the nonpatients. (2) A significant discrepancy exists between a psychoneurotic's or schizophrenic's achieved mobility and aspired mobility.

RESEARCH DESIGN

This research was designed so that class position, on the one hand, and the presence or absence of diagnosed mental illness, on the other, could be controlled. It was reasoned that by holding each of these factors constant, the assumed interrelationships between social mobility and mental illness could be found. To achieve this objective, samples of psychoneurotic and schizophrenic patients in classes III and V were drawn from the psychiatric population of the New Haven community. Comparable control samples of nonpatients from classes III and V were drawn from the general population.

The samples were selected from nonadjacent classes because we believed that the influence of class factors could be determined more easily in persons from distinctly different classes than in persons from adjacent classes. Classes III and V were selected for the following reasons: (1) These classes have sharply different prevalence rates for treated schizophrenia and psychoneurosis; (2) they have not been studied carefully in previous psychiatric research; and (3) they comprise approximately 40% of the population of the New Haven community.

Each class may be characterized briefly as follows: Class III is composed of proprietors of small businesses, white-collar workers, and skilled manual workers, who are, for the most part, high school graduates. These people live in apartments and single-family dwellings in widely scattered residential areas. Class V is composed almost exclusively of unskilled and semiskilled workers who typically have an elementary education or less and who live in the most crowded slum areas of the city.

The combination of patients from 2 different diagnostic categories and 2 social classes, with nonpatients from the same classes, pro-

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[2] Supported by Mental Health Act Research Grant MH 263.

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TABLE 1

NUMBER OF PATIENTS AND NONPATIENTS STUDIED BY CLASS

Social Classes	Patients		Nonpatients (Controls)
	Neurotics	Schizophrenics	
III	13	13	30
V	12	12	30
Total	25	25	60

duced the 6-cell research design presented in Table 1.

A glance at Table 1 will show that each of the 4 cells for patients is filled with a minimum of 12 cases; each cell for nonpatients is populated with 30 individuals.

All individuals in the study, patients and nonpatients, are white and between the ages of 22 and 44. These age limits were imposed because attention was focused upon patients who presumably had reached adult responsibility and adjustment, but who had not entered the involutional period. The ages of the nonpatients were held to the same limits so comparisons could be made between the 2 groups.

Detailed data were collected on each patient with an extensive schedule divided into 4 main parts. The first part was filled out by a psychiatrist in interviews with the patient; the second was filled out by a sociologist in an interview with members of the patient's family of orientation and his family of procreation. In addition, considerable material came from the clinical record and an additional clinical interview of the patient by a project psychiatrist. As a last step, the team developed 2 assessment schedules to evaluate the data systematically. While the data were being assembled on the patients, the sociologists interviewed the nonpatients with a different schedule.

The representatives of the samples of patients and nonpatients to their appropriate universes was crucial to the research. This was complicated by the differences in the way the 2 samples were obtained. Patients who met the requirements of the research design were selected individually. The nonpatients, on the other hand, were selected at random from the 5% systematic sample of the community's population used in earlier phases of the research. Representativeness of the nonpatients was determined by comparing them with the systematic sample of the general population on the following variables: age, sex, religion, ethnic origin, and class score. The patients were compared with the psychoneurotics and schizophrenics in the psychiatric population on the same variables. No significant difference was found at the 5% level of confidence on any variable when the 2 groups were compared with their parent universes. In short, the patients were representative of all psychiatric patients in their appropriate age, sex, class, and diagnostic groups, and the nonpatients were representative of the systematic sample of the New Haven community in their age, sex, and class groups. When the representativeness of the 2 samples was established, assumed interrelations between class position, mobility factors, and mental illness were tested.

Mobility was measured by the use of Hollingshead's 2-factor *Index of Social Position*. This Index is based upon education and occupation. The number of years of school the individual has completed is scored on an educational scale; likewise, his occupation is scored on an occupational scale. Then, the scale value for education is multiplied by a weight of 6, and the scale value for occupation by a weight of 8. The resulting calculated score is assumed to be an Index of the individual's position in the community's class structure.

Two Index scores were computed on each patient and nonpatient. The first was the score of the individual's parental family; the second was the score of the individual being studied. The score of the parental family was assumed to be the social base line of the individual in the study. The difference between the scores of the parental family and the individual in the study, whether positive or negative, was used as the measure of the individual's achieved social mobility. If the difference was positive, the individual was considered to be upwardly mobile; if negative, he was viewed as downwardly mobile.

When achieved social mobility had been defined, the crucial question was: Have the psychoneurotics or the schizophrenics in either class III or class V been more mobile or less mobile than the nonpatients? Answers to this question were sought by making a

series of comparisons of social mobility scores of the nonpatients with the patients. The t-test was relied upon in each comparison to determine significance of difference between the mobility scores of the control and the patient groups.

FINDINGS

Proposition I: Achieved Social Mobility in Class III.—Class III individuals, both patients and nonpatients, were far more mobile than class V individuals. This finding was in accord with the general assumption that class III represents one subcultural group, and class V a distinctly different one. As we expected, achieved social mobility in class III was almost entirely upward. Only 3 individuals were downwardly mobile by as many as 10 points; one was a nonpatient, one was a psychoneurotic, and one was a schizophrenic. All others were upwardly mobile by varying amounts. Three patients moved upward more than 50 points. All were females; one was a psychoneurotic; the others were schizophrenics.

The average amounts of mobility achieved by the nonpatients, the psychoneurotics, and the schizophrenics, in class III, are depicted in Fig. 1, which shows that in comparison with their parental families, the nonpatients moved upward 20 points, the psychoneurotics 27 points, and the schizophrenics 36 points on the *Index of Social Position*. The difference in achieved upward mobility between both the psychoneurotics and the nonpatients, and the schizophrenics and the nonpatients, is striking. The data indicate a definite interrelationship between social mobility and mental illness. The controls have been the least mobile, and the schizophrenics the most mobile of the 3 groups.

When the distinct relationship had been found between achieved social mobility and both psychoneurosis and schizophrenia, social mobility scores were computed on the patient's adult brothers and sisters to see if they had been as mobile as the patient. This operation showed that the psychoneurotic and schizophrenic patients in class III had been significantly more mobile than their siblings.

The next step in the analysis was to determine if the nonpatients, the psychoneurotics, and the schizophrenics had the same, or different, parental base lines. Components included in the base line were: (1) the *Index of Social Position* of the family of orientation; (2) ethnic origins, and the number of generations in the United States; (3) religious affiliation; and (4) community of origin. No significant differences were found on any of these factors when the nonpatients in class III were compared with the psychoneurotics and schizophrenics. Two conclusions were clear from these comparisons; first, that the 2 groups, nonpatients, psychoneurotics, and schizophrenics, had come from an essentially homogeneous social and cultural base; any differences that existed were of a random order; second, we infer the demonstrated differences in achieved social mobility in the present generation were produced by the differential efforts of the individuals in the study to attain more education and to get better jobs than their parents had had. In addition, the inference may be made that the psychoneurotics, and especially the

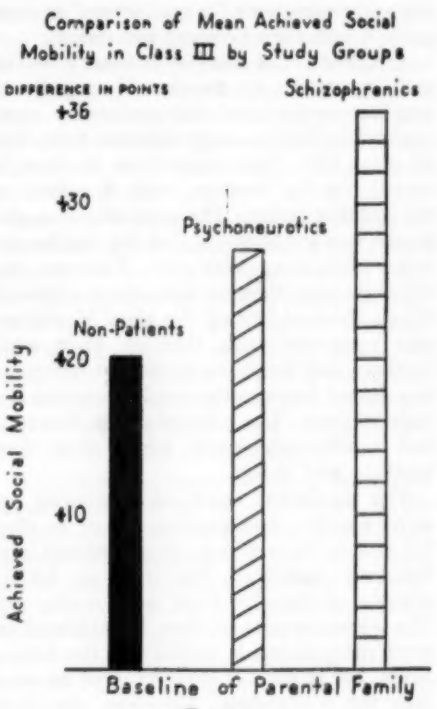

FIG. 1

schizophrenics, were "overachievers" in comparison with their brothers and sisters.

Achieved Social Mobility in Class V.—The mobility pattern for the class V nonpatients, psychoneurotics, and schizophrenics summarized in Fig. 2 is very different from that of class III. The nonpatients in class V moved, on the average, only 8 points up the mobility Index. The schizophrenics also moved upward 8 points, but the psychoneurotics made a 12 point gain. This was significantly more than the nonpatients achieved. When the mobility of the class V patients was compared with that of their adult brothers and sisters no significant difference was found between the psychoneurotics and their siblings. The schizophrenics, however, had significantly lower scores than their brothers and sisters.

The significant relationship between upward mobility and psychoneurosis in class III and in class V was in accordance with the first postulate. The data on schizophrenia, on the other hand, are not clear-cut. The schizophrenics in class III achieved almost twice as much mobility as the nonpatients, but in class V they achieved no more than the nonpatients. However, the sharp differences in the mobility patterns in the 2 classes were in agreement with expectations. They reinforced the assumption that the quantity of social mobility is different from one class to another. They suggested also that individual case records needed to be studied carefully to determine the meaning the selected mobility factors had for individual psychoneurotics and schizophrenics in both classes.

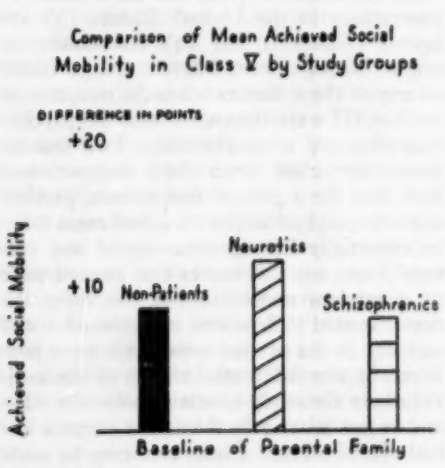

FIG. 2

Proposition Two.—The attempt to assess the meanings that these mobility factors had for the patients gave rise to the second proposition. It assumed marked discrepancies between achievement and aspiration. Achievement was defined, in accordance with proposition one, as the position a patient had attained educationally and occupationally. What he said he wanted to achieve in each area was defined as aspiration. The difference between what was attained and what was hoped for was defined as discrepancy. The discrepancy, if any, between achievement and aspiration was assumed to be a stress vector in the patient's life.

Throughout the analysis of the data on achievement and aspirations we were concerned with the question: Are the aspirations voiced by these patients expressions of their behavior or are they phantasies without any overt behavioral correlate? In order to answer this question, each patient's history was studied to determine if evidence supported his statements of his aspirations. If his premorbid behavior indicated he had made more or less consistent efforts to bridge the gap between his claimed aspirations and his actual achievements, it was inferred that verbalized statements of his hopes were characteristic of his behavior.

Educational Discrepancies—Class III.—The data on educational achievement, aspiration, and discrepancies in class III are summarized in Table 2. This tabulation shows that the average class III psychoneurotic completed slightly more than 1 year of college, but he aspired to a college degree. The average class III schizophrenic completed

TABLE 2

MEAN EDUCATIONAL ACHIEVEMENT AND ASPIRATIONS MEASURED IN YEARS OF SCHOOL FOR CLASS III PSYCHONEUROTICS AND SCHIZOPHRENICS

	Years of School	
Educational	Psychoneurotics	Schizophrenics
Achievements	13.3	14.1
Aspiration	16.1	16.4
Discrepancy	2.8	2.3
	$F=8.688, 1/25$	$F=6.988, 1/25$
	$p < .01$	$p < .05$

2 years of college, and he, too, wanted to finish college. The discrepancy between educational achievement and aspiration among the class III psychoneurotics and schizophrenics is significant. These patients worked hard to achieve their educational goals. Moreover, they viewed education as the one area of activity that would enable them to realize their goals in life. As a consequence, they blamed their failures upon either their lack of education or the limited educational opportunities open to them during their childhood and adolescent years.

The class III schizophrenics emphasized education more strongly than the psychoneurotics; and they implemented their desires by going to school a year longer. Every schizophrenic had put forth great personal effort to obtain his education. They were usually good students and they enjoyed school. Typically their problem was to get enough education to prepare for the job they wanted. They worked upon the premise that if they could get enough education they would get the desired job, then they would be accepted socially, and their problems would be ended. Finally, they looked upon education as a panacea for their personal and social problems. Unfortunately, their educational strivings were usually without encouragement or guidance from their parents.

Class V.—Educational achievements and aspirations among the class V patients are summarized in Table 3, which shows that the discrepancy between achievement and aspiration is significant for both the psychoneurotics and the schizophrenics.

The class V psychoneurotics believed they could have had skilled jobs or clerical "positions" if only they had been able to finish high school and had received specialized vocational training. They stated their aspirations largely in terms of a better job, and they looked retrospectively to education to solve their economic problems. The function of education, as they looked back upon it, was to prepare an individual for a good job. A good job meant a higher standard of living, and, if one lived well, what other problems could one have?

TABLE 3

MEAN EDUCATIONAL ACHIEVEMENT AND ASPIRATIONS MEASURED IN YEARS OF SCHOOL FOR CLASS V PSYCHONEUROTICS AND SCHIZOPHRENICS

	Years of School	
Educational	Psychoneurotics	Schizophrenics
Achievement	8.9	7.3
Aspiration	13.8	10.6
Discrepancy	4.8	3.3
	$F=14.158, 1/23$	$F=6.462, 1/23$
	$p<.01$	$p<.05$

The class V schizophrenics all encountered educational frustrations. Most of them were compelled to leave elementary school, after the eighth grade, by a combination of economic circumstances and parental indifference, if not hostility, toward education. As adults, they regret their lack of an education, and they are aware that they cannot improve their positions without more education, but they feel incapable of obtaining it.

Occupational Discrepancies—Class III.—When we turn from the educational to the occupational area, we find a definite discrepancy between the actual and the idealized in both classes and diagnostic groups. However, there are no essential differences in the occupations engaged in by the class III psychoneurotics in comparison with the class III schizophrenics. Both groups have moved in the course of their lives from manual work into work that requires specialized training and reasonably smooth interpersonal relations. The men are employed as clerks, salesmen, and supervisors; the women are employed, or they were before marriage, as secretaries, elementary teachers, nurses, and technicians. Although the occupational achievements of both sexes have been substantial, their aspirations are far above their accomplishments. The men would like to be professionals or in business for themselves; the women would prefer to be professionals, or married to professional men. The occupational reference groups of the patients include lawyers, doctors, professors, engineers, artists, musicians, and business executives. Only two class III patients were satisfied occupationally; one was a psychoneurotic and the other was a schizophrenic; both were females.

Class V.—The class V patients, both psychoneurotics and schizophrenics, were either semiskilled or unskilled workers. They felt their jobs were unsatisfactory; they worried about how long they would last, the nature

of the work, that they did not pay enough to meet the needs of their families, that there was no advancement, and that the job carried no status.

The jobs they aspired to included: nurse, teacher, veterinarian, engineer, master mechanic. Not a single class V patient realized his aspirations in the economic area. As a group, they were aware of the connection between "good" jobs, "steady" jobs, jobs that paid a "living wage," and a dreamed-of standard of living. Occupational aspirations were particularly strong among the women. Apparently they visualized the connection between education, jobs, and mobility better than the men. This may be the reason why they were more frustrated in their verbalizations of their hopes than the men. About one-half of the men hoped for a steady, semiskilled factory job; the remainder dreamed of skilled jobs. Their wives, however, wanted more money, shorter hours, and higher status jobs for their husbands.

Discussion

Our data demonstrate that neurotic and schizophrenic patients are more upwardly mobile than the average population. They show stronger upward mobility than their parents and siblings. Considering that the more severe forms of neurosis and schizophrenia are crippling diseases and seriously impair man's efficiency, such upward mobility and its concomitant achievement in occupation and education are interesting and even surprising. These data are further proof that the downward drift hypothesis of schizophrenia is not correct(6, 7). It seems that neurotics and schizophrenics, at least prior to the onset of illness, are achievers and possibly overachievers.

Not all schizophrenics and neurotics are upwardly mobile. In our case material a few patients were hardly mobile; one schizophrenic patient and one neurotic were downwardly mobile. In our clinical experience we have encountered other cases of downward social mobility. While upward mobility seems to be the rule, downward mobility occurs. This fact in itself demonstrates that mobility features are not essential and necessary concomitants of mental illness but rather phenomena which vary according to social and psychological characteristics of the specific case. Based on clinical observations, we found downward mobility to be a rare but serious concomitant of neurosis. It occurs particularly in the self-destructive character neuroses, as they were dynamically described by Karl Menninger(9). We have noticed it in chronic alcoholism and other drug addictions, in various forms of antisocial behavior, and in chronic invalidism.

While actual upward mobility in our patient population is definite and marked, mobility aspirations in both the schizophrenic and neurotic population are even more striking. The discrepancies between achievement and aspirations in the individual patient as well as in our total diagnostic groups are interesting quantitative indices of the patients' lack of ego strength and their subsequent flights into phantasy. We have used occupation and education as indices denoting achieved and aspired mobility. Mobility can be most clearly discerned in these spheres; but other spheres did not escape our attention. In the females in our series of patients we were impressed by the use of physical attractiveness, charm, and sex in the broad sense to achieve mobility. Such strivings often centered around the effective choice of a mate for marriage. When ineffective it resulted in various socially disapproved forms of sexual behavior, ranging from the behavior of the lonely and frustrated spinster who either avoided or rejected men to the more flagrant forms of antisocial behavior, such as promiscuity or prostitution. Frustration and conflict over frustrated mobility aspirations may be discerned in all these spheres.

Our material has led us to some questions about the nature and genesis of social mobility. American culture, generally speaking, prescribes upward mobility; but how does the individual learn to be mobile? What accounts for the various forms of mobility? What are the underlying identifications with parents and siblings or the rejection of such persons and their ego ideals which might explain various forms of social mobility? Such problems will be dealt with in further publications.

There is one more problem we would like to touch upon. In previous work(14) we

demonstrated that patients of the upper classes more frequently receive psychotherapy, particularly insight therapy, than patients of the lower classes who receive supportive psychotherapy and organic treatments more frequently. We assume that these differences can be explained, not only by economic conditions, but by differences in attitudes, values, and belief systems between middle-class therapists and their patients(13). To participate in insight therapy patients must understand, to a certain extent at least, what the therapist is driving at and share some of his basic convictions, motivations, and values, such as the strong motivation to think and act rationally and to fulfill one's own potential and help others to fulfill theirs. Although very few lower-class patients receive insight therapy we felt the need to explain how such exceptional patients are capable of participation in such therapy. Our clinical experiences indicate that such lower class patients are socially upwardly mobile individuals, who aspire to have values similar to those of the therapist. In contrast to such upwardly mobile patients who are often good therapeutic risks, the downwardly mobile patient—usually a self-destructive, self-punitive, moral masochistic person—is likely to show negative therapeutic reactions. We wish to stress that while social mobility does not explain the etiology or treatability of mental illness, it can, when properly understood—as one of many factors—help us to arrive at a better understanding of the complex and puzzling conditions we have to recognize, treat, and understand.

Summary

1. The hypothesis that social mobility is related to psychoneurosis and schizophrenia was tested as part of a large study on social class and psychiatric disorders in the metropolitan New Haven community.

2. Methods in studying the social mobility of 25 psychoneurotics and 25 schizophrenics divided between social classes III and V and a number of control subjects are described.

3. These psychoneurotics and schizophrenics are more mobile than the control subjects.

4. There is a discrepancy between achieved and aspired mobility in the psychiatric patients.

5. The implications of the above findings for phenomenology, etiology, and treatment of psychoneurosis and schizophrenia are discussed.

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EDUCATIONAL BACKGROUND AND JOB ADJUSTMENT OF PRIVATE HOSPITAL PSYCHIATRIC AIDES[1]

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THE PROBLEM

The present study is an investigation of the educational qualifications and job adjustment of persons employed as psychiatric aides in a private hospital. The primary purpose is to learn whether the job adjustment can be anticipated from data relative to the educational background. The immediate objective is to establish standards for use in selection of persons for employment as psychiatric aides at the hospital in question, and to increase understanding of the types of individuals who are best suited for work with mental patients in this type of setting.

BACKGROUND

Psychiatric aide selection is a problem which receives increasingly widespread attention, and studies have been made in a number of representative situations. Kline (1) investigated the problem at a Veterans Administration hospital and showed that a measure of personality adjustment would have contributed greatly to selection. Yerbury, Holzberg, and Alessi(2) were able to set up selection criteria for aides at the Middletown (Connecticut) State Hospital. They found a critically low score on the Army Beta test, and found that certain Rorschach responses were more frequent with poor rather than satisfactory aides. Barron and Donahue(3) studied aide selection at an Arkansas state hospital and learned that persons with dull normal ratings on the Otis intelligence test were more likely to make a satisfactory adjustment as aides than those with higher Otis ratings. High scores on the psychopathic deviate scale of the MMPI were found to be associated with unsatisfactory adjustment. The study at the Menninger Foundation, reported by Hall(4), showed few significant correlations between test scores and grades in their experimental school for psychiatric aides. The correlation coefficients which did appear to be significant were attributed to chance variation.

Most investigations have approached the problem through psychological tests with only secondary attention to the educational background. The present paper investigates the use of specific educational data, obtainable on the application form, in the screening of psychiatric aide applicants.

PROCEDURES

An unselected group of 98 psychiatric aides, including all aides newly employed within a period of 5 months, constituted the sample for study. These aides were employed through procedures routinely used in the hospital at that time. Educational data were used specifically in their selection only to the extent that high school graduation or better was requisite to employment. Six months after employment, job adjustment was determined on the basis of length of service and of personnel ratings. These ratings were made routinely on all aides and were independent of the educational data. The total group was then subdivided according to the job adjustment rating, by two methods. The first was for the purpose of learning if there were differences in the educational background of satisfactory aides which distinguished them from the partially satisfactory or unsatisfactory aides. Three subdivisions of this grouping, with criteria for inclusion in each, are: (1) Satisfactory (40 aides): employed for a minimum of 6 months with at least average personnel ratings; (2) partially satisfactory (29 aides): employed 6 months but rated as below average; rated as average or better, but employed less than 6 months; and (3) unsatisfactory (29 aides): employed less than 6 months *and* rated as below average.

The second subdivision was to determine if

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above-average adjustment as aides could have been predicted from the educational factors. The groupings in this division, and criteria, are as follows: (1) Above average (26 aides): employed a minimum of 6 months *and* rated above average; (2) average (43 aides): employed 6 months but rated as average or below; rated as above average but employed less than 6 months; (3) below average (29 aides): identical with the unsatisfactory group above.

Comparison of the satisfactory with the partially satisfactory and unsatisfactory aides, and of the above average with the average and below average aides was then made in terms of 17 educational variables (Table 1) relating to level of education, academic excellence, area of specialization, and extracurricular participation. Differences were tested by the Chi-square method, with Yates' correction formula applied, and by the *t*-test for significance of differences in means, where applicable.

FINDINGS

It was found that the satisfactory aides were significantly different from the unsatisfactory and partially satisfactory aides on only 2 counts, namely, the fact of having earned academic honors in high school and college, and the fact of having participated in literary extracurricular groups (publications, literary clubs, poetry clubs, etc.). Differences were significant on the .02 to .05 level. In the second grouping (Table 2), the above-average aides were more frequently found to have been psychology or sociology majors if they had graduated from college (.02 to .05 level of confidence); more frequently to have graduated from school or college with academic honors (.02-.05); more often to have been participants in at least one extracurricular group in high school or college (.02-.05); and more often to have participated in student government (.01-.02), musical activities (.01-.02), and in social service and religious extracurricular groups (.01) in high school and college.

Educational levels and frequency of participation in extracurricular groups were also compared by means of the *t*-test for significance of differences between means. The satisfactory aides averaged $14.92 \pm .28$ years of education, the partially satisfactory aides, $14.41 \pm .28$ years, and the unsatisfactory aides, $14.23 \pm .32$ years. The differences between these mean levels did not reach the .05 level of significance (Table 3). When the above average subgroup was compared with the average and below average categories, differences were significant. The above average group had a mean educational level of $15.50 \pm .33$ years, the average group, $14.33 \pm .28$ years, and the below average group, $14.23 \pm .32$ years. Differences (Table 3) were significant on the .01 level.

The satisfactory aides averaged participation in $3.50 \pm .33$ extracurricular groups in

TABLE 1

DIFFERENCES IN EDUCATIONAL BACKGROUND OF SATISFACTORY AND UNSATISFACTORY PRIVATE HOSPITAL PSYCHIATRIC AIDES

Criterion	Chi²	P
College graduation	1.6695	.30-.50
Two or more years of college	.8339	.50-.70
At least one year of college	.6799	.70-.80
College graduate, psychology major	2.1165	.30-.50
College graduate, psychology or sociology major	3.8733	.10-.20
Academic honors, high school or college	7.7609	.02-.05
College graduate with academic honors	1.9973	.30-.50
Participation in one or more extra-curricula activities group	4.9443	.05-.10
Major extra-curricular office, high school, or college	2.2349	.20-.30
Major or minor offices, high school or college	3.9001	.10-.20
Participation in student government, high school or college	2.7767	.10-.20
Participation in sports, high school or college	2.7798	.10-.20
Participation in musical activities	1.2315	.50-.70
Participation in literary activities	6.0407	.02-.05
Participation in dramatics	2.0601	.30-.50
Participation in forensics	3.7134	.05-.10
Social service and religious activities	3.2038	.20-.30

TABLE 2

DIFFERENCES IN EDUCATIONAL BACKGROUND OF ABOVE AVERAGE, AVERAGE, AND BELOW AVERAGE PRIVATE HOSPITAL PSYCHIATRIC AIDES

Criterion	Chi²	P
College graduation	3.4278	.10-.20
Two or more years of college	5.6164	.05-.10
At least one year of college	3.6193	.10-.20
College graduate, psychology major	3.1298	.20-.30
College graduate, psychology or sociology major	6.8111	.02-.05
Academic honors, high school or college	6.6961	.02-.05
College graduate with academic honors	2.0296	.30-.50
Participated in one or more extra-curricular groups, high school or college	6.4689	.02-.05
Major office in extra-curricular group, high school or college	3.9516	.10-.20
Major or minor offices	3.9335	.10-.20
Participation in student government	8.5924	.01-.02
Participation in sports	2.1452	.20-.30
Participation in musical activities	8.6632	.01-.02
Participation in literary activities	3.4945	.10-.20
Participation in dramatics	1.8899	.20-.50
Participation in forensics	2.2306	.30-.50
Participation in social service and religious activities	9.9738	.01 -

high school or college, the partially satisfactory aides 2.69±.35 groups, and the unsatisfactory aides, 1.90±.32 groups. The difference between the mean frequency of participation of the satisfactory and unsatisfactory groups is significant (Table 4) at the .01 level; the difference between the satisfactory and partially satisfactory groups did not reach the .05 level of confidence. The above average aides averaged participation in 3.96±.47 groups, as opposed to 2.72±.27 for the average aides, and 1.90±.32 for the below average aides. Differences between the means for the above average and below average groups is significant on the .01 level, and between the above average and average groups, on the .03 level (Table 4).

SUMMARY

Seventeen educational criteria were examined to see if they differentiated between psychiatric aides whose job adjustments were rated as satisfactory, as opposed to those whose job adjustments were unsatisfactory or partially satisfactory, and those whose job

TABLE 3

DIFFERENCES IN MEAN EDUCATIONAL LEVELS OF PSYCHIATRIC AIDES WITH VARYING JOB ADJUSTMENT

Groups compared	Differences in means	Standard error of differences	t	Significance
Satisfactory and unsatisfactory	.695	.425	1.635	Below .05
Satisfactory and partially satisfactory	.515	.40	1.04	Below .05
Above average and below average	1.27	.459	2.81	.01
Above average and average	1.17	.43	2.72	.01

TABLE 4

DIFFERENCES IN MEAN EXTRACURRICULAR PARTICIPATION BY PSYCHIATRIC AIDES WITH VARYING JOB ADJUSTMENT

Groups compared	Differences in means	Standard error of differences	t	Significance
Satisfactory and unsatisfactory	1.60	.46	3.48	.01
Satisfactory and partially satisfactory	.81	.48	1.69	Below .05
Above average and below average	2.06	.57	3.61	.01
Above average and average	1.24	.54	2.29	.03

adjustment was above average, as opposed to those who were rated as average or below. It was found that satisfactory aides were distinguished from others on only 3 variables, namely, academic honors in high school or college, participation in literary extracurricular activities in high school or college, and the mean number of extracurricular activities. The above average aides could be differentiated from the average and below average aides by the frequency of psychology or sociology majors if college graduates, by the frequency of having earned academic honors either in high school or college, by the frequency of having taken part in at least one extracurricular group, by the fact of having been members of student government, musical, and social service or religious activities in high school or college, by the average number of years of education, and by average number of extracurricular activities. It is concluded that the consistent evaluation of these educational criteria would assist materially in the selection of applicants who would likely make above average job adjustments as psychiatric aides in the present situation, but that it would be of less value in selecting those whose job adjustments would be at least satisfactory.

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EMOTIONAL AND PSYCHOLOGICAL FACTORS IN EPILEPSY

General Clinical and Neurological Considerations[1]

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In an effort to understand and manage the epilepsies, the clinician has recognized with growing clarity the importance of *heredity, brain damage,* and *psychological factors.* These are not mutually exclusive.

The inheritance of a tendency to convulsive seizures was implied in marriage laws in 2000 B.C. It was given statistical support by W. R. Gowers in the nineteenth century, who found an hereditary background in 35% of his cases(1). The sharpest definition has come from the contemporary study by William Lennox that indicates if one of a pair of identical twins has seizures, attacks will also develop in the co-twin in 84% of the pairs(2).

The effect of brain damage was noted by Hippocrates in 460 B.C.(3). In the late nineteenth century Hughlings Jackson made a fundamental contribution to the clinical appraisal of seizures. These he attributed to excessive neuronal discharges and believed the pattern of the seizure to be an indication of the site of a lesion in the brain (4). Support of this was soon afforded by the animal experimentation of Fritsch and Hitzig(5) and that of Ferrier(6). In 1897, Sigmund Freud, on the basis of studies of epilepsy in infantile cerebral palsy, declared that there was no intrinsic difference between this and "genuine" epilepsy. He believed demonstrable lesions must exist in the cerebral cortex(7). But the full development of Jackson's concepts awaited the present-day work of Wilder Penfield and his associates(8).

The importance of psychological factors has varied in perspective as our general knowledge has advanced. In antiquity, epilepsy was linked with insanity, in that both were attributed to the malevolent influence of an indwelling demon. This association was given scientific credence by the studies carried out in the asylums of the eighteenth and nineteenth centuries by Tissot(9), Esquirol(10), and others. This was correct in part, as some with severe brain damage had both an organic psychosis and recurrent seizures. Nevertheless, this caused a significant delay in the separation of the epilepsies from the psychoses and from hysteria.

In the second decade of this century, Pierce Clark(11) offered psychoanalytic concepts as the full explanation of convulsive seizures. After analyzing 25 young men and women with epilepsy, he felt the seizures represented a profound subconscious striving that included the wish to return to the mother's womb. This idea was brought into conflict by the development of electroencephalography. Introduced by Hans Berger (12), a psychiatrist, in 1929, and elaborated by Gibbs(13), Jasper(8), and others, it showed graphically the validity of Jackson's hypotheses. With the swing from psychoanalytic concepts to electro-physiological explanations, Stanley Cobb(14) and Frank Fremont-Smith(15) are among those who have contributed balance to the present approach to the psychological factors in epilepsy.

Today, there are 3 psychological factors that command the attention of the clinical neurologist: (1) Emotional problems that arise as a reaction to the seizures; (2) emotional problems that act as a precipitant to individual seizures; and (3) emotional problems that contribute to the pattern of seizures. This latter interpretation must be made with full appreciation of the anatomical and physiological substrata.

Two cases are presented to illustrate the preceding:

The first case is one of a pair of identical twins who will be referred to as Edward. His brother, Peter, was born first, with a vertex presentation, the patient 9 minutes later, by breech presentation. There was a single placenta. The father and the

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[1] Read at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1955.

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mother's sister had experienced convulsions in childhood. Three brothers were not remarkable.

At 1½ years of age, the patient fell down 8 steps striking his head against a stone. Immediately thereafter he seemed sleepy and was not acting just right. One and one-half hours later he had a generalized convulsive seizure. During the next week, whenever this infant would strike his head against the rail of the crib he would have an attack. This occurred 7 times.

At 9½ years of age, he was struck by his father's car, but not injured. Edward describes this incident as follows: "I was coming back from Mass when my father backed the automobile out of the driveway. He turned a way I did not expect and the front bumper hooked me and threw me against the front of the car. I was not hurt but badly scared. Father bawled me out, shouting at me." One hour later there was a major seizure.

Three months later, after a frightening picture show, there was a second attack. Again, a seizure occurred following a prolonged period in crowded traffic during which the family temper was lost. Another time an attack followed a tooth extraction. The general frequency was one attack every 2 or 3 months.

When first seen at the Neurological Institute of New York, in February 1950, at age 11, Edward had had 12 major seizures in the previous 19 months. In these attacks, he had no subjective warning, but a sudden loss of consciousness. *Objectively*, the patient emitted a stuttering sound, his eyes rolled back, he became rigid and then shook. No focal aspect was noted. Neurological examination revealed no significant abnormality. Electroencephalography showed generalized high amplitude rhythmic slow waves during hyperventilation. His twin brother showed a similar record to a less marked degree. Little significance was attached to this.

In the 19 months during which he had repeated seizures, the patient did poorly in school and received lower grades than his brother Peter. His father described him as introspective, and his mother, as being subdued. She adds that during one examination in the 5th grade, Edward, who was indecisive about his answers, remained in school all afternoon. His writing was poor. In contrast to Peter, he always hung back at school entertainments.

Psychological evaluation[8] at that time showed the Verbal I.Q. to be quite similar for both twins, their range being in high average. Edward had fewer Rorschach responses, and an abnormal Szondi. For the first test (1950) the 2 compared as follows: Verbal I.Q.: Edward 119, Peter 113; Rorschach Total R: Edward 7, Peter 22; "M" Responses: Edward 2, Peter 8; Szondi: Edward—markedly disturbed, Peter—within normal limits.

The management in this case included the establishment of a better understanding by the parents, reassuring and encouraging the patient, separation of the twins at school and the control of the attacks by effective anticonvulsant medication. Since the initial examinations there has been but one seizure—in early 1951.

In re-evaluating this case 4 years later, March 1954, the following progress was noted: In the new school, although nervous at first, Edward improved scholastically and in his general performance. Both boys did exceptionally well during 7th and 8th grades. Each in his respective school last year received the medal of excellence for the best over-all scholastic average. They are now in high school. Peter is vice-president of his class and Edward is secretary of his fraternal order. In the summer they both work and participate in community affairs. The mother states there is little difference in the two boys—Edward being perhaps a little more certain of his knowledge and more outgoing in his play and work activity.

In discussing the former period during which he was having seizures, Edward states: "At first, that is, with the first attack or two, I thought, 'This is something that happens once in a life time.' Then when it was repeated several times, I didn't know. I got nervous, I did not do well in school, particularly in the 6th grade. My mathematics was bad. My writing was bad. I was not scared, but I was not relaxed. I was more careful. I was less sure of myself. In the 7th and 8th grades and now in high school, my math is much better and my writing has improved."

Psychological evaluation in March 1954, gives a more exact appraisal of the improvement indicated in the recent history. Both boys are superior in Verbal I.Q. There is a marked improvement in Edward's Rorschach responses, while there has been a decline in those of Peter. The Szondi for both is within normal limits. For comparison between the 2 evaluations see Table 1.

Comment.—In this case, the evidence would indicate that heredity played a small part and brain trauma a considerable part in establishing the recurrent seizures. Emotional factors were influential in precipitating

TABLE 1

COMPARISON OF PSYCHOLOGICAL EVALUATIONS OF A PAIR OF IDENTICAL TWINS, AFTER 4 YEARS

	(1950)	(1954)
Verbal I.Q.		
Edward.....	119	130
Peter.....	113	129
Rorschach Total R		
Edward.....	7	39
Peter.....	22	17
"M" Responses		
Edward.....	2	7
Peter.....	8	1
Szondi		
Edward.....	Markedly disturbed	Within normal limits
Peter.....	Within normal limits	Within normal limits

[8] The details of these psychological examinations were reported by Molly Harrower (16).

at least 3 and probably more of the childhood attacks. Of most importance, however, was the stress, evoked by the recurrent seizures, that interfered with academic performance and interpersonal relations. With medical control and better understanding on the part of the patient and his parents, the stress was alleviated and the emotional problems resolved.

The second case is the daughter of a well-bred family. The father has spent a career in foreign service; the mother is a charming woman, overprotective and given to worrying. One brother is not remarkable. At the age of 16 months, the patient fell, striking the right side of her head. Within the same year she had malaria. Neither was considered serious at that time. At 6 years, she began to have periodic abdominal discomfort. This occasioned a laparotomy at which nothing was found.

At 10 years of age, she began attending a school in Spain, the only English-speaking school in the city where her family resided. The teacher and fellow students were greatly liked by the patient but there was one unpleasant aspect. The toilet facilities were filthy. In recalling this, the patient states that her mother was very fastidious about the toilets in their various residences, insisting that everything be kept scrupulously clean. After trying the school facilities on 2 or 3 occasions, much against her will, the girl made her needs await her return home, often fearing this would not be possible. On many occasions she ran all the way. She does not remember discussing this with anyone. She attended this school for 3 years. At the end of 2 years, at 12 years of age, she had her first typical seizure. In the same year, her menses began.

Subjectively, the attack was anticipated by a feeling of being far away. Sounds seemed to "dim out." She had difficulty or inability to form words. There was a sensation of warmth in her abdomen and later, after this became meaningful to her as the forewarning of an attack, she experienced a feeling of panic. She had complete amnesia for the remainder of the episode. With the return of awareness, she complained of fatigue, unhappiness about the event, and occasionally a mild, right frontal headache.

Objectively, the first changes noticed were a smacking and wetting of her lips while her eyes opened wide in a frightened stare. Following this, there were clawing motions of both hands over the upper abdomen and such outcries as: "I want to go to the bathroom! Nobody knows what a pain I've got. I've got to go to the bathroom." When the attacks first occurred she would then attempt to leave the room. In later seizures, she simply prepared her clothes for an evacuation, but never completed the act. The end of the attack was heralded by expulsion of considerable gas by mouth. The attack usually lasted from 2-5 minutes and was followed by 5-20 minutes of apparently normal activity without memory of the event, or by sleep of varying duration. In addition to these typical attacks that occurred as often as 10-20 times a month there were many fragments consisting only of the warning phase. At 13 years of age she had a single Jacksonian seizure that began on the left side.

The typical psychomotor attacks continued until 17 years of age. In this year she was placed on medication and shortly thereafter entered college.

For 4 years she did not have a full attack, but experienced the warning phase about once a month. During this period, the patient was separated from her mother and from the friction that existed between them. Upon returning home from college, her attacks resumed in spite of medication.

Twelve years after the onset of her seizures, in March 1946, the patient was admitted to the Montreal Neurological Institute for further evaluation. She was then 24 years old.

Upon admission, there were no significant neurological findings. Electroencephalography revealed a well-defined focus of random spike activity in the right anterior temporal region. Under local anesthesia, a bone flap was turned and the dura reflected, exposing the right temporal and central regions. Electrocorticograms were obtained and stimulation was carried out over the exposed brain. When the searching electrode was passed through the temporal lobe to the under-surface, a very active, multiple spike dysrhythmia was recorded.

The temporal lobe was then lifted, and stimulation carried out on the inferior and mesial surface, producing the beginning of a typical seizure. Obviously agitated, the patient said, "Hang on to me." Observers noted masticatory movements and contractions of the left hand. This episode persisted for 20 seconds. Afterwards, the patient said, "That was an attack. That went as far as panic. Stomach, head, and panic were all there that time." The patient did not report being aware of the mouth movements. Repeated stimulation elicited the remark, "Here we go again. This is it." and a similar seizure ensued, of 15 seconds duration (stimulus intensity 2 volts).

The surgeon observed that the inferior and mesial surfaces of the temporal lobe appeared rather yellowish and a little tough. A few scattered adhesions were present between the dura and the pia-arachnoid.

A large portion of the right temporal lobe was removed, the excision extending 5 cm. along the fissure of Sylvius and 8 cm. along the base, sparing the auditory area in the posterior part of the first temporal convolution. The dura, bone flap, and scalp were closed in layers.

In the second postoperative year, the patient had 2 seizures, Jacksonian in type, which started with tingling and movement of the left hand, and progressed as far as loss of consciousness. These contained none of the elements of the preoperative psychomotor attacks. Since that time, a period of 5 years, she has had no further attacks. During this period she has taken no medication. She is now 31. A small, postoperative, left upper quadrant visual field defect persists, but there is no other apparent physical or psychological residuum. She is completing the work for a master's degree in chem-

istry, and has become an integral part of a research laboratory staff.

Comment.—In this case, a discharging lesion from a damaged area in the right temporal lobe was demonstrated. The functions of the temporal lobe are complex and not clearly understood. The Montreal school holds that it is the repository of memories and perhaps of understanding and judgment. Seizure discharges from this region alter consciousness and are commonly reflected by smacking and sucking movements of the lips and tongue. In addition, a wide variety of automatic movements or psychic phenomena may be observed. The occurrence of the latter is usually associated with a focus near the insula or along the inferior mesial surface. From this site gastrointestinal responses occasionally occur. In a number of cases, particularly those whose ictal expression is hallucinatory, the added psychic factors simulate emotionally charged elements from past experience. In this second case, the pattern of the automatism is considered an example of this.

Summary

Two cases are presented to illustrate the importance of emotional and psychological factors in epilepsy. Attention is directed to the personality changes that arise as a reaction to seizures. It is noted that emotional stress may act as a precipitant to individual seizures. Finally, it is pointed out that elements from past experience, of particular emotional significance, may be incorporated into the clinical pattern of seizures that arise from a discharging lesion in the temporal lobe of the brain.

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LONELINESS AND SOCIAL CHANGE

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I

Rapprochement between psychiatry and sociology has developed rapidly during the last few years. In theory and in research there is more collaboration than ever before and every prospect that this interdisciplinary trend will continue for some time to come. The present discussion is a case in point. It lies in the emerging field of social psychiatry (or psychiatric sociology)—in the rich borderlands where these two sciences of man can work together with mutual benefit. The aim of the analysis that follows is to show that certain emotional problems cannot be understood adequately unless changing conditions of the larger social environment are included in the framework of thought. In other words, we shall attempt to interpret psychological phenomena in the light of certain broad changes that have occurred in our society.

II

American society is highly dynamic and social scientists usually recognize this important fact in their interpretations of human nature. However, it is comparatively easy for psychological scientists to become so preoccupied with the study of individuals, particularly with those whose deviations cause difficulties, that they fail to appreciate the processes of social change which are an integral part of a more comprehensive interpretation. Instead, they postulate a given social order which is assumed to be fixed and unchanging —as part of the natural (or supernatural) order of the universe. To illustrate this point, let us take an example from child psychiatry. In the conceptual framework of an individualistic psychology maternal rejection is viewed as an aberration of unique individuals whose special dynamics require study and therapy. Now this approach to the problem is not completely satisfactory because it fails to take into account the broad influence of the feminist movement upon American women. The rejecting mother manifests tendencies which are, to some extent, typical of a whole class of women who have been encouraged to cultivate outside interests as means of self-expression. Such women may become decidedly ambivalent about the maternal role. The point here is that such ambivalence is not merely individual deviation from an assumed norm of "proper" conduct; it also represents a type of conflict engendered in our culture by the new opportunities for women that have opened up in recent decades. True enough, studies of individuals are likely to reveal why certain women become highly antagonistic to their children but, even in these cases, the attitude may be aberrant only in part. A residue of feeling remains that can be accounted for only by reference to the changing status of American women, especially those of the highest educational levels. It may be that the feminist movement has had many adverse effects upon children but it serves no useful purpose to condemn such women without understanding the cultural influences that shape their thoughts and feelings.

Similarly, there are current psychological explanations of extramarital sex which ignore the realities of social change. The Kinsey statistics give evidence that extramarital sexual behavior occurs more frequently nowadays than it did at the beginning of the century; but this trend is overlooked by those who insist upon interpreting extramarital relations as individual deviations from norms of monogamy which are assumed to be universally and absolutely valid. In many instances such an "explanation" of adultery is little more than an ill-disguised defense of traditional morality, where clinical terms are substituted for direct moral condemnation without altering the underlying emotional bias.

III

The problem of loneliness provides an excellent demonstration of the principle that psychiatric phenomena have sociological dimensions. A sense of isolation is a major

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symptom in various neurotic and psychotic states but, according to a number of theorists, loneliness is widespread in contemporary society, having sociological origins far beyond the field of psychopathology. In his analysis of the social conditions producing loneliness Erich Fromm stresses a long-range historical factor, namely, the whole liberal-democratic struggle against the authority of church and state(1). Modern man has won a succession of battles for freedom but, looking back from the vantage point of the twentieth century, it appears that there were liabilities inherent in these victories. The freedom gained is "freedom from" rather than "freedom to." Men are lonely today because these emancipating triumphs severed the "primary ties" that united them with others in the pre-individualistic period. We now have more individuality in democratic societies but this advantage has been purchased at a large psychological price. Fromm then proceeds to show how we can develop a positive freedom which provides both individuality as well as a sense of social unity, thereby destroying the loneliness resultant from the negative freedom so cherished by our democratic forefathers.

Fromm's brilliant analysis of the psychiatric significance of certain historical changes represents a distinct contribution but, from the standpoint of the sociologist, it needs to be supplemented at many points. Industrial-urban society of the twentieth century has a number of characteristics that seem to be conducive to loneliness and we shall outline a few of these briefly.

Our society shows a definite decline in primary-group contacts. (Primary groups are those face-to-face groups such as the family, play-group, neighborhood, or village which provide relationships of intimate fellowship.) The immediate family is smaller than it was 50 years ago and, as far as population experts can now judge, postwar increases in the birth rate will not reverse the general trend toward the small family. This means that both adults and children have fewer intimate associations within the family group. Moreover, close relationships may be obstructed by factors that separate the members of the small family today. We have already referred to the mother who participates in various activities outside the home. Under certain conditions frequency of the mother's absence may produce affectional deprivation both for her and the children. Even if she stays home, her hostility may have an isolating effect upon the children. Likewise, the father will seldom see his children, especially when they are small, if most of his time and energy are given to the job. Or, when he is home, he may have a preoccupied air that makes him unapproachable. This situation will be especially frustrating to sons who, in both home and school, find themselves almost exclusively under the influence of women and thereby deprived of companionship with adult males. As far as siblings are concerned, the contemporary emphasis upon grouping children by age tends to minimize relationships between brothers and sisters in the same house.

This loss is still greater when the larger kinship group is considered, for modern mobility separates relatives and lessens communication. The kinship solidarity of a rural society where relatives live near each other and work together is undermined by the movement of people from place to place. In many families today relatives see each other only during special occasions such as holidays, weddings, or funerals.

Even within the same community family and kinship ties may deteriorate as occupational or class differences introduce barriers to free and easy communication. Parents and other kinfolk commonly encourage the young to be ambitious (the desire for success is, after all, a basic value of our culture) but the movement toward higher socio-economic status may set off a process of alienation. Even before the adolescent gets out of school he may begin to perceive that the standards and practices in the social class to which he aspires are different from those in his own background. As a result of this observation the manners, morals, and precepts of the family may be looked upon with growing condescension or mistrust. Actually, in the interest of a good social adjustment, the ambitious child cannot afford to cling to a set of standards that are not functionally adequate in his new occupational or social position. However, neither the parents or other relatives are ordinarily able to appreciate the functional significance of alienation but are

more likely to feel hurt and neglected as relationships deteriorate to perfunctory visits that yield little affection. For his part the young person may also feel isolated as a result of rising above the familiar background of his childhood, especially during the transitional period before he fully accepts or is fully accepted into the new class environment with its new standards and associations.

The intimacies of neighborly contacts also tend to decline in the larger cities. Frequent changes of residence prevent neighbors from becoming well acquainted in the personal sense characteristic of primary groups. Apartment dwellers may not know or care who lives on the same floor, communication being limited to formal courtesies. Tendencies away from friendly spontaneity are also the result of social prejudice. In the neighborhoods of the cities various races, nationalities, and religions live together with a degree of necessary tolerance but the barriers of prejudice tend to prevent informal communication and thus augment loneliness. Over and above these conditions there is the wariness of the city dweller who hears of so many crimes and confidence games that he grows suspicious of his fellow man and withdraws into an impenetrable shell.

While these informal associations of primary-group intimacy have declined in the modern world, formal, impersonal relationships are on the increase. We meet many people not as persons but as functionaries; that is, we expect of them and get from them nothing beyond the performance of a particular function. The man who drives the bus or sells us a suit of clothes fulfills a function, usually without giving anything of himself. Similarly, the physician or the teacher participates in patterns of relationship so impersonal in character that they provide little or nothing in the nature of human fellowship. Such segmental contacts are more frequent in urban areas but they exist everywhere in our society.

The stress on impersonality is quite evident in the modern bureaucracy that has developed as a result of technological progress. (A bureaucracy is a highly organized activity, usually involving a large number of people, where special functions are fitted together into departments and hierarchies of power.) Not only in government and business do we find increasing bureaucratization of life but also in education, law, medicine, religion, recreation, and many other pursuits. The teacher in a school system, the physician in a hospital, the lawyer who works for a business enterprise, or the clergyman in a church organization become involved in a whole network of patterned relationships. The good bureaucrat knows his place in the social structure, knows his function and status, and thinks impersonally, avoiding impulsive spontaneity. In other words, he develops a mind-set appropriate to highly organized and stratified relationships. Thus, technological advances have exerted mighty influences upon human character.

It might be thought that the coordinated efforts required in large administrative units would lessen the isolation of participants. A naïve outsider, seeing such coordination and noting the first-name friendliness existing among associates, might easily conclude that the bureaucracy is a complex pattern of cooperative relationships among highly socialized beings. Yet this estimate is a superficial behaviorism that overlooks the emotional restraints implicit in formalized relationships. As suggested above, spontaneous fellowship and impersonality simply do not mix. Moreover, the feelings generated by competition are detrimental to the development and maintenance of friendliness. Friendly feelings toward fellow workers may be quite real, of course, but the other side of the ambivalence may be even more significant. This is the side of competition. In a competitive situation a person may fear that friendly colleagues are scheming behind his back and blocking his advance directly or indirectly. In the higher echelons of competition the struggle may go on continuously, not only at the office but also at dinner parties or on the golf course. One must constantly be on the alert to advance his cause—and that cause is always himself.

Though much more psychosocial research is needed in this area, we venture to suggest that the sense of isolation may be considerably less in the lower ranks of an economic organization. Here workers are not necessarily in competition with each other. Income and status may be equal and employees may

belong to a union that stresses and strengthens their unity of outlook. Under such conditions spontaneous feelings can be expressed more readily and cliques of "buddies" develop to provide companionship both on and off the job. Such persons do not enjoy the prestige of outstanding success but they do experience fellowship less adulterated with fear and mistrust.

Mobility as a factor in modern loneliness has already been mentioned but it deserves further consideration. In addition to its disintegrating effects upon family and neighborhood there seems to be a pervasive emotional result: people who keep moving from place to place tend to develop a sense of detachment that is isolating. One can observe this attitude in the tourist who remains only a few days in one place. Highly mobile people seem to acquire a tourist state of mind as a permanent characteristic, participating in various group activities without feeling deeply that they belong. This rootlessness tends to destroy many of the emotional values implicit in group life, encouraging, instead, a vicious circle where restless frustration leads to further mobility which, in turn, breeds additional frustrations resulting from isolation.

Vertical mobility—movement from one social class to another—also produces a sense of loneliness, for, as mentioned earlier, it means an attenuation of earlier social ties. For present purposes it does not seem necessary to cite statistical evidence on the amount of such upward or downward mobility; suffice it to say that it is a widespread social phenomenon in the United States (2). Upward mobility is especially stimulated by the comparatively low birth rates of the upper classes and by the expansion of educational opportunities for children of lower socio-economic status. We encourage youth to get ahead and applaud their successes; at the same time we tend to be blind to the psychological liabilities of this process. Fortunately these are mitigating circumstances. In the first place, the sense of isolation tends to decline as the person becomes more fully adjusted to the new class culture. Secondly, the new status is likely to be only moderately higher or lower than that of the early period, so that the frustrations involved in the transition are less serious than they might be. Nevertheless, while it persists, the loneliness associated with vertical mobility is a significant aspect of the general problem under discussion.

IV

We have outlined four major types of influences in our industrial-urban society that appear to augment the problem of loneliness. Subjective factors increase the difficulties still further. In a culture such as ours, where friendliness is highly valued, persons develop ideals and expectations that tend to magnify the sense of isolation resulting from these changes in objective conditions.

It should be emphasized that this sociological analysis in no way contradicts a psychiatric approach. Certain individuals develop a pronounced sense of isolation and it is the purpose of psychotherapy to give attention to the unique circumstances in the background and present relationships of such individuals in order to relieve distress. Our point is that some degree of loneliness is indigenous to our society; this condition does not stem entirely from patterns of circumstances peculiar to certain individuals.

This point of view seems to have important implications for the processes as well as the goals of psychotherapy and we venture to discuss two of these in a tentative fashion.

(1) To what extent is the patient's sense of isolation an individual deviation and to what extent is it a typical product of environmental forces? A community survey of mental health might reveal that, in some instances, the patient's grievances are repeated over and over again by large numbers of people. Psychotherapy could be greatly illumined by sociological research that would place at the disposal of therapists relevant knowledge about the community in which the patient lives—its various groups and their interrelations, intragroup processes, institutions, the class system, ethnic minorities, etc. Would not such knowledge enable the therapist to come to grips more accurately and adequately with the personal problems presented by the patient? For example, various predisposing and precipitating factors may be found during investigations of the larger social environment. Concerning treatment and recovery, detailed knowledge of the community and its sub-cultures might help the

therapist to deal more intelligently with the problems encountered by the patient in his daily life. Such social-science studies might also enlarge the psychiatrist's understanding of social reality, thereby enabling him to assess the patient's grasp of reality more adequately.

Community studies are now being made by interdisciplinary teams. The Yorkville community mental health research study, sponsored by the department of psychiatry, Cornell University Medical College, and the New York Hospital, with a research staff consisting of psychiatrists, sociologists, anthropologists, psychologists and social workers, is a striking example of what we mean (3). In the future therapists treating residents of communities where such mental-health research has been done will be able to draw upon new funds of sociological data. Perhaps, as time goes on, clinical reports will be issued on the value of such knowledge to psychotherapy. It may turn out that the social sciences are more valuable to psychiatry than we thought.

(2) In addition to its relevance to the therapeutic process, social research may be useful in determining the practicable limits of therapeutic success. To put the matter in crude terms, can the psychotherapist expect to do more than bring the patient up to the level of "normal" frustration? (We raise this question because of its methodological importance but it would be tempting for the therapist to exploit these considerations as a rationalizing device when treatment is relatively unsuccessful.) We have tried to show how loneliness results from certain *normal* conditions in social structure and relationships. Our analysis thus suggests, in terms of broad theory, that there are normal (or modal, to use the statistical term) types of loneliness as well as deviant types. From this point of view the practicable goal of psychotherapy becomes defined more clearly: to reduce a sense of isolation to normal proportions. If the psychiatrist does not possess reasonably accurate conceptions of society in general and the patient's environment in particular, he may expect more of the patient—and more of himself—than is sociologically justified.

To put it briefly, the goals of therapy are not formed from the Utopian ideals of dreamers. Rather, they represent pragmatic possibilities of mental health in a changing society whose vast, pervasive tendencies cannot be excluded from the psychiatrist's office.

V

It may appear from what has been said here that the frustrations of normal social living set distinct boundaries within which psychotherapy must operate. On the contrary, the limits imposed by social conditions are not fixed once and forever in a dynamic society. Past experience shows that many social conditions have been improved after the general public became interested and enlightened. As it stands now, many people have very little understanding of the isolation in their daily existence; or, having some insight, they are at a loss to know what can be done in the way of improvement. Public enlightenment can best come from psychiatrists and social scientists. The American people seem to appreciate as never before the importance of mental health, especially in relation to child development. Yet much more research and educational work are required to bring about a fuller understanding of the mental-hygiene significance of the whole complex social environment in which we live today. This is a large project but preventive psychiatry will not come of age unless it succeeds.

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PRELIMINARY REPORT OF A CONTROLLED MENTAL HEALTH WORKSHOP IN A PUBLIC SCHOOL SYSTEM *[1]

SEPTEMBER 1953–FEBRUARY 1954

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PURPOSE

If preventive psychiatry is to have any meaning, it must be addressed to those persons who predominantly influence the patterns of child growth—parents and teachers. This study has been directed to the latter group—the men and women who administer the school programs and who teach in the classrooms. Mental health workshops and seminars have been carried out in the Boston area particularly by Berman [5] and in the Grosse Point area near Detroit, Michigan, by a group from Wayne University [6] as well as in other locales. In this study we were primarily interested in assessing the adjustment of teacher and administrator groups by means of psychological tests given before and after a 15-week seminar conducted by a qualified psychiatrist and contrasted with a control group of teachers and administrators exposed to the same psychological tests at the same time.

OUTLINE OF THE EXPERIMENT

A mental health workshop was set up in the public schools of the City of New Rochelle which has a population of 62,000. The entire group of about 400 teachers was offered an opportunity to attend a seminar in mental health to be held evenings once weekly for 1½ hours over a 15-week period. Thirty-eight of these teachers volunteered. A second similar workshop was set up for the principals, assistant principals, and heads of departments who were required to attend their seminars. Controls were set up consisting of 2 additional groups, one matching the teachers on the basis of sex, age, grade taught, length of service in the system, and the second made up of the same administrative group from a neighboring city of the same size.

All 4 groups were then given a battery of psychological tests at the beginning and at the end of the 15-week workshop period. The testing instruments were: (1) the Rotter Sentence Completion Blank; (2) the Minnesota Personality Scales; and (3) a sampling questionnaire on mental hygiene attitudes, an inventory devised by one of us (F. B.). The Rotter Test provides an adjustment score based upon qualitative analysis of the completed items as they are related to various life areas and attitudes of the testees. Areas tapped included fears, worries, aspirations, regrets, etc. The Minnesota Personality Scales tap 5 areas of adjustment including social adaptation, family relations, emotionality and economic conservatism. It was felt that these areas comprise underlying emotional reactions and trends which theoretically should be related to the over-all concept of "good adjustment."

Our basic assumption was that a course of 15 lectures and discussions by a qualified psychiatrist should bring about positive changes in attitudes measurable by test scores purporting to measure the aforementioned variables. This would be particularly important if the 2 control groups, one of teacher

* Aided by a grant from the Board of Education, New Rochelle, N. Y., and Mental Hygiene Association, Westchester County, New Rochelle Committee. We wish to thank Mr. Roland Parker, psychological extern at Mount Sinai Hospital, for his help with the statistical portion of this study.

[1] Read at the 110th annual meeting of The American Psychiatric Association, St. Louis, Mo., May 3-7, 1954.

[2] From the Dept. of Psychiatry, College of Physicians and Surgeons, Columbia University.

[3] Adjunct Professor of Psychology, New York University, Washington Square College.

[4] Superintendent of Schools, New Rochelle, N. Y.

[5] Berman, L.: Mental Hygiene for Educators: Report on an Experiment Using a Combined Seminar and Group Psychotherapy Approach. Read before the APA May 3, 1950.

[6] Round-Table, annual meeting APA, Committee on Academic Education, May 1950.

and one of supervisor, were not exposed to the training-discussion experience. The data were statistically evaluated by means of a "t" [1] test for the significance of the difference between the tests and subtests of the various groups.

We were interested in determining whether these persons could be influenced to the extent that they show a more relaxed and understanding attitude toward their pupils. Observations made by the psychiatrist conducting the seminars (E. D. J.) will be discussed to give our impressions of factors involved in the teaching procedures as well as indicating weaknesses or strengths in the technique. The seminars were conducted with approximately ½ hour of didactic lecture plus one hour of free discussion. The lecture was given at *any* time during the 1½-hour period. This material is basically the same as that used in other teacher workshops and includes such items as normal personality development, the concept of conflict, anxiety and mechanisms of defense. Case material was used to illustrate many of the points and this was augmented by problems brought up for discussion by the participants in the workshops.

ANALYSIS OF TEST RESPONSES

Preliminary Comments.—In making an evaluation of the findings obtained by means of a rigorous statistical analysis of the tests, certain factors must be taken into consideration. Among other things, these concern the conditions under which the experimental groups volunteered for the experiment.

(1) It is known that a substantial number of volunteers dropped out of the program when informed that attendance was not obligatory and when assurance was given that administrative personnel would not be informed of individual defections. This would suggest that the term "volunteer" needs clarification in this situation, since it is not, in the school community, necessarily synonymous with volition. Like the "wish" of the commanding officer in the army, it is interpreted as a command.

[1] *t* is the critical ratio, that is, the difference between the means divided by the standard deviation of the differences.

(2) Analysis of attendance records indicates that a median of 12 and an average of 10.7 sessions represents exposure to mental hygiene information for this group of teachers. If we consider how much individual psychotherapy is required to bring about changes in personality and outlook and how much effort must be expended in group therapy to obtain such results, the conclusion is inescapable that expectations of farreaching changes would have been unrealistic. It is possible, of course, that tests designed to measure *acquisition of knowledge* might have shown positive shifts, but in this case "facts" rather than insights would have been acquired on the purely verbal plane. Even so, more than the median number of sessions would have been required for such results.

(3) The statistically significant difference between those who felt that the project should be continued after the first 15-week seminar and those who felt it should be dropped might represent expressions of resentment stemming from deprivation of leisure time activities. In fact, in the Rotter blank some of the teachers stated they would rather have been elsewhere doing something else. This is a further indication that future groups must be truly voluntary, *i.e.*, they must be assured that their attendance has no administrative implications one way or another.

(4) Random selection of the 5 best and 5 poorest adjusted teachers revealed striking differences which could presumably affect the emotional climate of the classroom. In the well-adjusted group we found a zestful attitude toward life, the feeling that parents are helpful and affectionate, trust in people, a positive feeling toward members of the opposite sex, and good intellectual functioning associated with a definite life plan and acceptance of the past.

The maladjusted group was characterized by tensions, phobias, compulsions, obsessive concern with the past, either parental fixations or disappointments, distrust of others, conflicting life plans, negative attitudes toward the opposite sex, and overt social adaptation with inner resentments.

It would appear from these findings that length of teaching experience apparently

plays a negligible role in easing the path to a good adjustment. There would also appear to be a negative correlation between years of education and adjustment, with the possibility that maladjustment might lead to a drive for more education as a way of alleviating feelings of inferiority and insecurity. What stood out in this sample was the focal importance of good family relations and parental figures in early childhood.

The Tests.—The Rotter Incomplete Sentences Blank (ISB), College Form, consists of 40 items such as: I like.....; The only trouble.....; My father..... which the subject is required to complete in accordance with his or her real feelings. The author states that he obtained a corrected split-half reliability of .84 when based on the records of 124 male college students and .83 when based on 71 female students. The scoring plan involves judgments and matching of sentences against criterion sentences. Inter-scorer reliability for 2 scorers trained by the author was .91 when based on 50 male records and .96 for 50 female records.

The reliability of the instrument is based upon biserial correlations of .50 and .62 between the ratings of "maladjusted" and "adjusted" given to 72 females by their instructors in classes in effective study and in mental hygiene and their scores on the ISB, and for a group of 78 males evaluated similarly.

In this experiment all blanks were scored by an MSSW from the New York School of Social Work who has had broad experience with tests and measurements.

The Minnesota Personality Scale consists of 5 parts, as follows: (1) Morale, attitudes toward the legal system, attitudes toward education, general adjustment; (2) feelings of inferiority, social adjustment, social preferences, social behavior; (3) family attitudes, home adjustment; (4) health adjustment, emotional adjustment; (5) economic conservatism.

The authors report reliability coefficients ranging from .91 to .95 for the 5 parts of the scale (100 men, 100 women).

In this study the precourse tests were hand scored and the postcourse tests machine-scored.

The Mental Hygiene Orientation Inventory by Brown was compiled from material in the literature upon child behavior, development, and adjustment, with the inclusion of factual material designed to test a specific knowledge background as a basis for judgments on the behavior of children. The following correlations were obtained:

Teacher experimental group.....	.80
Administrative control	.52
Administrative experimental	.65
Teacher control group.....	.20

With the exception of the last group, all correlations show a significant degree of reliability. The low correlation for the teacher control group is attributable to large *increases* in score between first and second tests.

These data indicate that no significant changes occurred in any of the groups on this test. Considering the influence of factors mentioned previously, there seems to be a slight tendency for the experimental teacher group to show a trend toward lower scores which might indicate that in individual cases certain changes of a positive nature took place. As a group however the differences are little better than chance.

There are no significant differences between pre- and post-scores for morale for the teacher experimental and the administrative control groups. It is interesting however to note that the administrative experimental group shows a significant improvement reliable at the .05% level of confidence, indicating 95 chances in 100 that the difference between means is a true difference. On the other hand, the teacher control group shows an even more significant difference in a positive direction without having been exposed to the lecture-discussion meetings. We may hypothesize that this group, which knew that it was a control, may have been motivated to better previous scores upon the basis of an increased level of aspiration.

Scores indicative of feelings of inferiority and social adjustment improved significantly for the teacher experimental group, but a similar increase for the teacher control group is also noted, again suggesting a level of aspiration factor.

Family attitude scores and home adjustment shows a significant trend for the teacher control group and highly significant positive

RESULTS

ROTTER ISB

Group	Mean (1)	Mean (2)	t	Significance
Teacher control	108.94	110.18	+0.55	Not
Teacher experimental	115.90	110.97	−1.53	Not
Administrative control	111.28	112.60	+0.31	Not
Administrative experimental	113.52	112.20	−0.46	Not

MINNESOTA PERSONALITY SCALE

PART I

Group	Mean (1)	Mean (2)	t	Significance
Teacher control	174.84	183.17	2.69	.01
Teacher experimental	175.71	177.45	0.90	Not
Administrative control	183.78	180.52	−1.14	Not
Administrative experimental	173.96	179.28	+2.53	.05

PART II

Group	Mean (1)	Mean (2)	t	Significance
Teacher control	220.99	238.51	4.49	.01
Teacher experimental	203.55	215.64	4.03	.01
Administrative control	228.84	245.41	1.37	Not
Administrative experimental	243.85	241.85	−0.54	Not

PART III

Group	Mean (1)	Mean (2)	t	Significance
Teacher control	151.36	155.48	1.91	.10 to .05
Teacher experimental	132.99	144.24	3.20	.01
Administrative control	134.78	152.15	7.86	.01
Administrative experimental	128.45	146.75	5.79	.01

PART IV

Group	Mean (1)	Mean (2)	t	Significance
Teacher control	170.00	163.98	1.72	Not
Teacher experimental	163.57	171.70	2.19	.02
Administrative control	150.73	167.50	4.91	.01
Administrative experimental	168.12	173.54	1.27	Not

changes for the other groups. It is therefore difficult to say whether the experimental groups improved in this area because of the course or whether all 4 groups felt that they had revealed too negative an attitude previously and were recouping their losses, so to speak, on the post-test.

The reliability of this section of the test is demonstrated by pre- and post-test correlations of .75, .70, .86, and .64 respectively, indicating that subjects tended to maintain their relative rank in the group despite score increases.

Health and emotional adjustment scores increase significantly for the teacher experimental and the administrator control groups. This again makes it difficult to assess the value of the course for the experimental group.

In spite of the fact that anonymity was guaranteed by the assignment of numbers to participants in the experiment, there were so many omissions of items on the economic conservatism scale as to invalidate the findings. Whether this was caused by the present political climate or by the fact that this scale came last in the test is uncertain, although the former hypothesis seems more valid in view of the nature of the items.

Summary of Minnesota Personality Scale.—Examination of the 4 scales of the Minnesota indicates that 5 significant differences between pre- and postscores in the experimental group were paralleled in the control

groups. It has been hypothesized that the control groups, *knowing* they were controls, tended to boost their scores and were therefore motivated by level of aspiration factors. Had this group been kept in ignorance of the experiment, one might conjecture that there would have been no significant differences. In that event, the significant increases for the experimental groups might have been attributed to the impact of the course material. Under the circumstances no conclusions can be reached with any degree of certainty.

It is interesting to note that the experimental groups are more sophisticated concerning mental hygiene information than are the control groups, although no significant changes are noted for any of the groups. No significant changes were obtained on the disciplinary tendency scale.

The following conclusions from the psychological test results may be advanced:

1. In order to test differences between experimental and control groups for an experiment such as this one, it is necessary to obtain the full cooperation of the experimental group.

2. The control group should remain in ignorance of its function in the experiment. It might be told that an effort is being made to test the reliability of the scales.

3. Since study of the Rotter and the other scales indicate many personal adjustment problems in the "normal" range, these protocols might be studied for the purpose of preparing a course which would have more personal meaningfulness for the participants.

4. The instructor for such a course should have understanding of the school milieu.

Observations on the Teaching Program

Teacher workshop group

In comparing this group to the administrator group, it was the feeling of the instructor that the teachers were less free to enter into discussion of any sort. They seemed to expect, and to some extent prefer, a lecture series rather than a seminar. However, once the discussion pattern in the seminars was established, the members tended to stick to classroom problems, avoiding personalities. Toward the end of the sessions, those who remained were freer in being critical of handling specific situations, but even so the group as a whole avoided being critical.

The group was roughly divisible into 2 sections:

(1) There were those apparently attending the workshop out of a feeling that it would be advantageous to their relationship with the administrators. Most of the members of this section dropped out by the eighth or ninth session. Individual members of this section (15-20 in number) expressed opinions regarding various child problems ranging from poor heredity, to lack of parental discipline, to need for strong, firm handling by teachers. Often the teacher's inability to handle various situations was blamed on overcrowding, lack of materials, etc., with denial that the teacher played any role.

(2) This section was made up of those attending more or less regularly and interested in students as individuals needing individual handling. Most of this section (20-25 in number) were apparently well oriented in emotional development and wanted guidance in practical application of theory. Some of this group remained because of personal problems for which they were seeking help through understanding others.

The first was mostly composed of the older teachers, while the second contained the younger ones. However, there were enough exceptions to cause little weight to be attached to age alone. Thus in section 2 were some of the oldest teachers, while in section 1 were some of the youngest. All members of both groups were concerned with salary matters, and this was often touched upon in some way. Toward the end of the sessions members of the second section wondered how those in the first section could be reached and handled so that their lack of psychologic

BROWN INVENTORY

Group	Mean (1)	Mean (2)	t	Significance
Teacher control	62.29	65.20	0.93	Not
Teacher experimental	71.70	71.80	0.67	Not
Administrative control	56.92	61.50	1.66	Not
Administrative experimental	70.75	69.60	0.46	Not

awareness would not undo their efforts. This question was also raised by the administrator group.

The problems causing most trouble to both teachers and administrators were those having to do with aggressive behavior. Sexual problems such as those arising from students seemed more easily handled by members of both groups. Aggressive problems would arouse a desire for primitive, retaliative, repressive measures often against their better judgment. Coupled with this was a feeling of frustration that nonretaliatory measures did not show such immediate results.

Both groups evidenced an intense desire to see quick results from their efforts on behalf of students. The long range point of view in the necessarily slow process of maturing was constantly stressed by the instructor. Frustrating to some was the need to understand the behavior of a child, even though they frequently lacked enough data to provide understanding.

ADMINISTRATOR GROUP

This group as a whole entered into discussions much more freely and the members were able to bring it more quickly to a personal level with more freedom to discuss each other's weaknesses and strengths. This was probably due, in part, to the greater cohesiveness and contact between members of this group in many other activities. They were concerned with the question of handling parents of problem children more than were the teachers, and they were also concerned with dealing with outside pressures of various sorts on school systems.

As a whole this group had more psychologic awareness than the teacher group, but there were variations among the members. The problem of selection of good teachers was repeatedly discussed, as well as the handling of those teachers now on their staffs who merely "put in time" or use the class for their own purposes. The instructor was impressed by the interest shown by all of them in the welfare of their students and appreciation of the student needs.

This group also evinced a desire for quick results, as did some of the teachers. There was considerable discussion about the role of the school, whether only the three R's should be taught, the results thus being measurable by tests, or whether the aim should be to provide an environment most suitable for the child's growth, with acquiring of knowledge only a part of the task, and thus not be able to have a measure of results of efforts. Many felt that the school system should provide more psychologic counseling for the staff with respect to individual problems of children. They also indicated that the lack of adequate community psychiatric resources was a handicap.

At the end of the last session several members expressed the feeling that they had gained from it and said "it was good mental hygiene for them even if it didn't solve all their problems."

Group therapy was not planned or expected. However, it became evident that this played a role in both experimental groups. As one principal said, "Even if I learned nothing else, it was a great help to me to learn that the other principals had the same problems that I did."

Conclusions

This experiment was carried out for the purpose of studying under control conditions a mental health workshop conducted by a qualified psychiatrist with a group of teachers and a group of administrators in a public school system. When 2 control groups were set up matching these 2 groups and the 4 groups exposed to a battery of psychological tests before and after the seminars, it was found that statistically significant changes occurring in the experimental group were paralleled by equally significant changes in the scores of the control group. Had the results of the experimental group been considered without reference to a control group, there would have been impressive positive changes in 4 Minnesota test categories for the teachers ("t" 's from 2.19 to 4.03) and in one category for the administrative experimental group (5.79).

Summary

1. A control mental health workshop was set up in a public school system. A volunteer group of teachers and the administrative

group of principals, assistant principals and heads of departments were separately exposed to 15-week 1½-hour seminars on mental health under the guidance of a qualified psychiatrist.

2. A control group was set up matching teachers as to age, sex, duration of service, and grade taught; also a control group of administrators from a neighboring community.

3. All 4 groups were given the same battery of psychological tests before and after the seminars.

4. Studies of the psychological test responses show that although there were statistically significant changes for the experimental group, these were also found in the control group.

5. It should be noted that if the pre- and posttesting of the experimental groups were evaluated without control groups the results could have been interpreted as excellent.

6. Further control studies are projected with varying size groups, different instructors, different methods of selecting participants, and varying the content of the lecture and discussion material.

CLINICAL NOTES

PALLIATIVE TREATMENT OF POLIOMYELITIS: PRELIMINARY REPORT ON USE OF COLLOIDAL IODINE SOLUTION

E. MIRANDA ORTIZ AND D. GONZALEZ CALZADA
LONDRES, MEXICO, D.F.

A series of 80 cases of poliomyelitis observed during a severe epidemic in Mexico City in 1948 was treated with slow intravenous or intramuscular injections of iriodine. Iriodine is a neutral, isotonic, colloidal iodine solution containing potassium iodide 10 mg., iodine 10 mg. and beta amylose 100 mg. in 5 cc. of distilled water. The rationale of the beta amylose colloidal medium is the fact that the iodine element is held firmly by adsorption, to be released as free iodine gradually as needed on contact with the blood.

The group included 5 acute cases, 65 chronic, and 10 which were omitted from consideration because of incomplete scientific data. In all 5 acute cases, treated exclusively with iriodine, tenderness, muscular pains, and contractions disappeared in 24 to 48 hours. All of these patients recovered completely in 3 weeks to 3 months, leaving no clinical signs of the disease.

All 65 chronic cases showed some degree of ultimate improvement, but none of the long-standing cases recovered completely. There were no ill effects from the medication except a mild rash in a few instances.

In the authors' previous experience with acute poliomyelitis in Mexico, the recovery rate was approximately 50%. In the present series, there was no deviation in results, inasmuch as there was 100% recovery in all 5 cases treated with iriodine. These results would seem to be statistically significant for a small series. However, further clinical investigation should be conducted on a larger scale.

COMBINED RESERPINE-CHLORPROMAZINE THERAPY IN HIGHLY DISTURBED PSYCHOTICS

WERNER TUTEUR, M.D.,[1] ELGIN ILL.

A pilot study of treating highly disturbed female psychotics with a combination of reserpine and chlorpromazine has recently been finished at Elgin State Hospital. The study differs from previous studies reported, inasmuch as the two medications were contained in 1 single capsule, each capsule containing 25 mgs. chlorpromazine, together with 0.25 mgs. reserpine. It was found that this relationship of the two drugs, namely, 100 mgs. of chlorpromazine to one mg. of reserpine, is highly feasible. Oral medication was used exclusively.

The patients were treated with chlorpromazine, reserpine, and the combination of the two, respectively, and it became evident that whenever the combination was used, considerably less of each drug was required to tranquilize the patient, and no side effects whatsoever were encountered in patients taking the combination. Examples of patients needing daily 900 mgs. of chlorpromazine and 9 mgs. of reserpine, respectively, when on these drugs, but merely 250 mgs. of chlorpromazine, together with 2.15 mgs. of reserpine in combination were observed. Other examples were patients who needed daily 800 mgs. of chlorpromazine and 6 mgs. of reserpine, respectively, but merely 375 mgs. of chlorpromazine, in addition to 3.75 mgs. of reserpine when on the combination. Similar relationships were observed in other patients.

It is felt that the chlorpromazine-reserpine combination issued in one capsule may assume considerable practical importance in the treatment of psychotic patients. It is easily applicable, effective, and because of the low amount of each individual drug, possibly free of side effects.

[1] Clinical Director, Elgin State Hospital.

HISTORICAL NOTE

CENTENNIAL OF SAINT ELIZABETHS HOSPITAL

WINFRED OVERHOLSER, M.D., Sc.D., L.H.D.

A few days before she died in 1887, Dorothea Lynde Dix remarked to a friend: "I think even lying on my bed I can still do something." It was an understatement. Although nearly three-quarters of a century have passed since Miss Dix's death, there is ample evidence that even from her grave she "can still do something."

Since early this year, Saint Elizabeths Hospital, one of many that came into being as a result of Miss Dix's long crusade on behalf of the mentally ill, has been observing its One Hundredth Anniversary. There are striking parallels between the history of Saint Elizabeths and the history of psychiatry in America. In both there is ever-recurring evidence of the influence of that remarkable Bostonian, Dorothea Dix, who was neither hospital administrator nor psychiatrist, on the care and treatment of the mentally ill not only in this country but throughout the civilized world.

To many people of her day, particularly during the early years, Miss Dix's practice of gathering facts at first hand about the plight of the mentally ill did not appear altogether proper. But if her methods were unsuited to a lady of her times, of one thing there can be no question: this eminently proper Bostonian did get results! State Legislature after State Legislature was jolted by the grim reality of the facts that she presented and impelled to action by the logic and humanity of the solutions that she proposed.

Miss Dix had one goal. That was to get the "insane" out of the jails, almshouses and dungeons and into hospitals. To a woman of Miss Dix's courage and resourcefulness, it was only natural, at least in retrospect, that the Congress of the United States should have become one of her targets. She did, in fact, "take on" Congress quite early in her career.

Nor was she at all modest in what she proposed—the setting aside of 5,000,000 acres of public lands and use of the income from these lands for the care and treatment of the mentally ill of America. When this audacious proposal failed, Miss Dix promptly increased her demands to 10,000,000 acres, and for good measure added 2,225,000 acres for the use of the deaf, dumb and blind! After one of the most expert lobbying efforts in the history of the country, the plan was approved by large majorities in both Houses of Congress.

Thus was the stage set for the establishment of "The Government Hospital for the Insane," long since known as Saint Elizabeths. The land bill was vetoed by President Franklin Pierce as an improperly paternalistic move on the part of the Federal Government, but Miss Dix's work was not yet done. She next turned her attention to the establishment of a Federal institution for the care of the insane of the Army and Navy of the United States—and as an afterthought—of the District of Columbia. The bill establishing Saint Elizabeths was signed by President Pierce on March 3, 1855.

The fact that the basic legislation was not passed until 1855 is a commentary on the informality of the times, for by that time the hospital was already in operation, construction having started in 1853. Of further historical interest is the fact that the original hospital building (now known as Center Building and still very much in operation) was a truly autochthonous structure, the clay for the bricks having been dug and baked on the hospital grounds.

Characteristically, Miss Dix's interest in Saint Elizabeths Hospital did not end with the passage of the necessary appropriations and other legislation. She picked out the site for the hospital, a high plateau overlooking the Anacostia River; she succeeded in procuring this site from the reluctant owner, Thomas Blagden, after other efforts had

failed; she chose and worked with the first superintendent, Dr. Charles H. Nichols; in short, it was through her efforts that Saint Elizabeths came into being.

It was Dorothea Lynde Dix who laid down the basic philosophy that has guided the work of Saint Elizabeths Hospital through a full century of operation. For it was she who wrote the act which begins: "The title of the institution shall be The Government Hospital for the Insane, *and its object shall be the most humane care and enlightened curative treatment* of the insane of the Army and Navy of the United States and of the District of Columbia."

Clearly it was the physical beauty of the site selected for the hospital, and not its history, that had attracted Miss Dix, for the original title of the institution, while not out of keeping with the forthright if somewhat grim practice of the times, did not reflect the happy coincidence that the tract on which the hospital was built was itself known from early times as the Saint Elizabeth's Tract, after Saint Elizabeth of Hungary, the patron saint of the sick and poor.

Almost from the beginning, the Government Hospital for the Insane began to be known informally as Saint Elizabeth's or Saint Elizabeths. This more beneficent title came into almost universal usage during the Civil War, when the hospital was devoted almost exclusively to the care of the wounded. The soldiers did not like to be referred to as inmates of an "insane asylum." Finally, in 1916, the name Saint Elizabeths was officially adopted, the grammatically necessary apostrophe having disappeared altogether somewhere along the way, a casualty either of carelessness or of mistaken notions as to its propriety.

The rules governing admissions to Saint Elizabeths, as well as the name of the hospital, have changed since the original act was written, but the objective of the institution as defined by Miss Dix has the same massive ring and authenticity today that it had when first enunciated a century ago. Nor is "the most humane care and enlightened curative treatment of the insane" applicable only to Saint Elizabeths; it can hardly be improved upon as a credo for the whole field of psychiatry.

The Centennial of Saint Elizabeths Hospital is being observed in 1955 not merely as the anniversary of the Federal Government's first mental institution; it is a rededication to the work started more than one hundred years ago by Dorothea Dix. The Centennial occurs at a time when there is growing recognition that that work is far from finished. Despite the great advances in our knowledge of mental illness and how to treat many mental and nervous disorders, our mental hospitals today, with few exceptions, are unequal either in personnel or facilities to the task imposed on them by an ever-increasing and ever-maturing population.

Nor have all of the fears, superstitions and other misconceptions that prevailed in Miss Dix's day been laid to rest or corrected. In an effort to break down some of these false notions about mental illness, a group of patients at Saint Elizabeths Hospital created a historical play, *Cry of Humanity*, in connection with the hospital's anniversary. The stage play has been seen by approximately 4,000 people of Washington and vicinity and has been widely acclaimed as a major step toward building better public understanding of the problems of the mentally ill. Portions of the play were also presented on a nation-wide television program and seen by an estimated 20,000,000 persons. So far as is known, this was the first time mental patients had appeared in a dramatic production on television without taboo-perpetuating masks. In each case, the patient, his parent, or guardian, and his attending physician gave consent to his appearance on the program.

Early in May, the Centennial Commission of Saint Elizabeths Hospital, an association formed with the aid of private contributions to assist the hospital in observance of its Centennial, and the Medical Society of Saint Elizabeths Hospital were co-sponsors of a two-day professional meeting at the hospital in which internationally-known psychiatrists from the United States and many other countries of the non-Communist world took part. The Commission expects to publish the proceedings of this conference.

One of the most unusual events that has occurred in connection with the Centennial

was the publication of an Anniversary Issue of *Mental Hospitals* (Volume VI—Number 5). This truly remarkable document was prepared as if for publication in 1855, and bears that date, together with the reproduction of an old drawing of the original building at Saint Elizabeths on the cover. Its various articles and comments out of the past should be required reading for psychiatrists generally. It is good to be humbled occasionally; it is a humbling experience to let Doctor Kirkbride and other "contributors" to this Anniversary Issue remind us, as they do so well, of how much was known about treating the mentally ill a century ago.

The remaining major events of the Centennial include a meeting at Saint Elizabeths of superintendents of other mental hospitals which Miss Dix was instrumental in founding or improving and the dedication of a new admission and treatment building at Saint Elizabeths, to be known as the Dorothea Lynde Dix Pavilion.

In the words of a reporter in his review of *Cry of Humanity* in a national magazine, "Pioneer Dix would have been heartened."

CORRESPONDENCE

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: May I insert a strong protest at the misleading report on "Physiological Treatment" which appeared as part of the Review of Psychiatric Progress 1954 in this year's January issue?

The reader might not imagine from the bland pronouncement that "insulin coma therapy stands up well through the years" that your journal alone had published two papers in 1954 that questioned the value of the therapy (David, H. P., Vol. 110, p. 775, and Lifschutz, J. E., Vol. 111, p. 466). Still less would anyone realize that an extraordinary controversy went on for months in *The Lancet,* one of the world's leading medical journals, following my own critical review ("The Insulin Myth," Lancet 53 II 964).

It seems to me quite a *tour de force* to achieve such omissions when the literature is scoured and space found for uncritical mention of the benefits of such hardy annuals as vitamin mixtures and tissue extracts.

Far from insulin coma therapy "standing up well," an increasing number of psychiatrists, some very eminent, have come to doubt whether it has cured a single patient.

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M.R.C.S., D. P. M.,
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COMMENT ON THE ABOVE

Editor, AMERICAN JOURNAL OF PSYCHIATRY:

SIR: Thank you for the opportunity of reading Dr. Bourne's letter of February 25 concerning insulin coma therapy.

As you know, insulin coma therapy has been administered under my supervision for the past 13 years and during that time we have treated approximately 300 patients. We have also had the opportunity of running a small series of schizophrenics on insulin with carefully chosen controls, chosen patient for patient before commencing insulin treatment, and the total group continued under identical environment, diet, nursing, and professional care, etc. From this small series (approximately 50), which however is much larger than Dr. Bourne's 9 patients he reported in the *Lancet* article "The Insulin Myth," we felt there was a definite suggestion that insulin coma reduced the duration of the acute schizophrenic illness. These patients in our series were followed over a period of a minimum of 3 years but we did not publish this comparison as we felt the number in the series was not adequate for thorough statistical treatment.

I continue to agree with the findings on the extensive series of the Temporary Commission on State Hospital Problems (1944) Insulin Shock Therapy, New York, and I fail to find in the Lifschutz article adequate follow-up, the longest follow-up being only 6 months, and apparently his controls were chosen after the conclusion of insulin coma on the treated group. David's article is a discussion in general of the various factors that he feels contribute to the difficulty of evaluation of insulin treatment, with no special consideration of any one series of patients.

I do not suggest that it has been conclusively established on a purely scientific basis that insulin coma therapy is of significant benefit in the treatment of schizophrenia for the simple reason that there are so many factors involved in this assessment, but on the other hand I find it much more difficult to be convinced from the various articles I have read condemning the therapy that the lack of therapeutic value has been conclusively proven. I believe it is the consensus of opinion among a number of us who have had a long experience clinically with the use of this treatment, that it is of benefit in at least one respect, namely, that it reduces the length of time that the patient suffers from

any one psychotic schizophrenic episode and that it is superior to electroshock in that the relapse rate of a schizophrenic group is much grea.er on electroshock alone as compared to insulin coma therapy alone. Certainly we feel that insulin coma therapy improves the possibility of early rapport, permitting the psychotherapy essential to any improvement in mental illness.

LORNE D. PROCTOR, M. D.,
Head of the Department of
Neurology and Psychiatry,
Henry Ford Hospital,
Detroit, Michigan.

Dr. Joseph Wortis who wrote the Review of Physiological Treatment in the January 1955 issue of the JOURNAL reported, "no comment."

FURNITURE OF THE MIND

Let us then suppose the mind to be, as we say, white paper, void of all characters, without any ideas;—how comes it to be furnished? Whence comes it by that vast store which the busy and boundless fancy of man has painted on it with an almost endless variety? Whence has it all the materials of reason and knowledge? To this I answer, in one word, from *experience*. In that all our knowledge is founded; and from that it ultimately derives itself. Our observation, employed either about external sensible objects, or about the internal operations of our minds, perceived and reflected on by ourselves, is that which supplies our understanding with all the *materials* of thinking. These two are the fountains of knowledge, from whence all the ideas we have, or can naturally have, do spring.

—JOHN LOCKE

PROCEEDINGS OF THE AMERICAN PSYCHIATRIC ASSOCIATION

THE ONE HUNDRED AND ELEVENTH ANNUAL MEETING ATLANTIC CITY, 1955

The 111th Annual Meeting of The American Psychiatric Association was held in Atlantic City, May 9-13, 1955. The meeting was called to order by the President, Dr. Arthur P. Noyes, at 9:45 a.m., Monday, May 9. The invocation was given by Rabbi Joshua Shapiro of Atlantic City. Owing to an unforeseen important engagement, Governor Meyner who was scheduled to welcome the Association, was not present and appeared on the program on Tuesday morning. President Noyes introduced the councillors and officers who were seated on the stage and then introduced President-Elect, Dr. R. Finley Gayle, and called on the Medical Director, Dr. Daniel Blain, to give his report. Dr. Blain presented a résumé of his activities both in Washington and throughout the Nation and the work of the Central Office during the past year. Dr. Crawford Baganz, retiring Speaker of the Assembly, reported on the activities of the Assembly of District Branches during the past year. Dr. David Flicker reported for the Committee on Arrangements, and then the Secretary gave a report of the membership statistics. As of March 31, 1955, the total membership of the Association has increased to 8,149. Of these, there were 2,144 Fellows, 4,389 Members, 1,163 Associate Members, 262 Life Fellows, 32 Life Members, 22 Honorary Fellows, 84 Corresponding Fellows, and 53 Inactive Members. This did not include, of course, the new applicants for membership. These were voted on during this meeting and will be given later on in this report. The Treasurer, Dr. Jack R. Ewalt, presented the treasurer's report, which appears in another section of these Proceedings. President Arthur P. Noyes then gave the presidential address, in which he emphasized the ever-widening scope of our field and the great need for introducing the broader concepts of the humanities into the teaching of our profession. President-Elect, Dr. R. Finley Gayle, replied in a suitable manner to the President's address, pointing particularly to the thoughtfulness and broad vision of the message it contained. The Chairman of the Program Committee, Dr. David A. Young, gave the report on the program, pointing out a number of changes that had to be made and that could not be included in the published program. It was noted that this year the program appeared in two sections—one which contained the titles, authors, and discussants, and the other, of a larger format, consisted of comprehensive abstracts of the papers and, as was found towards the end of the meeting, this was a very successful idea introduced by Mr. Robinson of the Central Office. The Secretary then read the memorial to deceased members and following this, the President adjourned the session at 11:30 a.m.

At the next business session for members on May 10, the Secretary read an amendment to the By-Laws recommended by the Council and one which will be published in the JOURNAL before it will be voted upon by mail ballot later this year. The Secretary then read the results of the mail ballots of last autumn, approving all five proposed amendments to the Constitution. These amendments were published in the JOURNAL and then were mailed to the membership for voting. The Honorable Robert B. Meyner, Governor of the State of New Jersey, was then introduced by the President and addressed the members of the Association, welcoming them to New Jersey and expressing his deep interest in the field of mental health and his firm determination to spare no efforts in dealing with the problems presented. The Secretary then presented Council's recommendations for the establishment of seven new district branches and the acceptance of four new affiliate societies. These

were as follows: (1) District Branches: Western Missouri, Eastern Missouri, Arkansas, Kansas, Westchester County, N. Y., Kentucky, and Oklahoma; (2) Affiliate Societies: Mid-Continent Psychiatric Association, Delaware Psychiatric Society, Dutchess County, N. Y., Psychiatric Society, and the Florida Society of Neurology and Psychiatry. Upon motions duly made and seconded in the case of each one of these, the membership approved these recommendations of the Council. In the absence of the Chairman of the Board of Tellers, Dr. Harvey Crandell, Dr. Robert S. Garber presented the report of the Board of Tellers for the election of officers. The total ballots mailed were 6,960; total ballots returned 4,374; invalid ballots 20. The officers elected for 1955-1956 were as follows: Francis J. Braceland, President-Elect; William Malamud, Secretary; Jack R. Ewalt, Treasurer; Incoming Councillors: Dr. Herbert J. Gaskill, Dr. Harvey J. Tompkins, Dr. S. Bernard Wortis; Auditor: Dr. Titus Harris (This office was abolished by recent amendment to the Constitution.)

There was a brief recess which was followed by the academic lecture, "The Biological Roots of Psychiatry," by Dr. Ralph W. Gerard who was introduced by the President.

At the next business session on the morning of May 11, the Secretary read the report of the actions taken by Council at its meetings on October 30-31, 1954, and May 7-8, 1955. These were approved by the membership. The Secretary then presented the recommendations of the Committee on Membership as approved by Council relative to the election of new members and changes of status of certain members, and these were duly approved by the membership—581 new members were elected at this meeting, which now brings up the total number to 8,730. Dr. John R. Rees, Director of the World Federation for Mental Health, was then introduced by the President and spoke on the activities of that organization and his hope that it would receive the backing of The American Psychiatric Association and its individual members.

The annual President's Banquet was held on the evening of May 11 and was very successful. The attendance was 856, an all-time record for an annual banquet. The Hofheimer award for a research project in psychiatry was presented to Dr. Philip F. D. Seitz of Indianapolis, for his work on developing new methods for studying the nature and causes of mental diseases. Two other research projects were cited for honorable mention—one by Dr. David Graham of St. Louis and the other by Drs. John Clausen and Melvin Kohn of NIMH. Certificates of Commendation were then presented by President Noyes to outgoing officers, councillors, and committee chairmen. Dr. Gayle then presented the certificate to Dr. Noyes, and Dr. Appel presented the past-president's badge to Dr. Noyes. Dr. Overholser presented the Mental Hospital Institute Awards which were as follows: the achievement award was presented to the Western State Hospital, Fort Supply, Oklahoma (Dr. Frank L. Adelman, Superintendent); honorable mention went to Muscatatuck State School, Butlerville, Indiana (Mr. Alfred Sasser, Director); to Metropolitan State Hospital of California (Dr. Robert Wyers, Superintendent); and the Boston State Hospital, Massachusetts (Dr. Walter E. Barton, Superintendent).

Dr. Noyes then announced a grant of $30,000 a year for three years from Smith, Kline and French Foundation for post-graduate training of psychiatrists. Dr. Braceland presented the first installment of a $10,000 grant from three members of the Association, for the purpose of furthering research in psychiatry. Dr. Curran presented the Isaac Ray Award to Professor Henry Weihofen of the College of Law of the University of New Mexico. The address of the evening was given by Professor M. F. Ashley Montagu on "Man and Human Nature."

At the next business session on Friday morning, May 13, the Secretary reported the actions of the Council at its meeting on the preceding day. On motion duly made and seconded, the membership accepted the report of the Secretary and approved the actions of the Council. The Secretary reported that the total registration at the annual meeting was 4,085, of which 2,046 were members, both representing all-time records for attendance. Dr. Smeltz reported for the Committee on Resolutions. His re-

port was approved by the membership and appears in another section of this report. The retiring President, Arthur P. Noyes, then presented the incoming President, Dr. R. Finley Gayle, Jr., of Richmond, who expressed his appreciation of the honor conferred upon him and briefly outlined his program for the coming year. The Annual Meeting of the Association adjourned at 5:00 p.m., Friday, May 13.

Resolutions

The following Resolutions were offered by Doctor George W. Smeltz, Chairman of the Committee on Resolutions:

1. *Resolved,* That the President, Members, and Fellows of The American Psychiatric Association express their appreciation to his Excellency Robert B. Meyner, Governor of the State of New Jersey, for his cordial welcome to our Association convened in Atlantic City for its 111th Annual Meeting, and for his sympathetic grasp of the needs for research, more adequate treatment and care for the mentally ill.

2. *Resolved,* That the Association does hereby record its very real gratitude to its beloved President, Arthur P. Noyes, for the wise and far-seeing leadership with which he has guided the membership and the affairs of the Association during the past year, and especially for his untiring and fruitful efforts to interpret to the membership and to the country at large, the Association's program and policies.

3. *Resolved,* That the Association expresses its thankfulness to the officers, Members of Council, and to Section and Committee Chairmen and Secretaries for the devotion with which they have pursued their duties, making possible the successful functioning of the Association throughout the year and during the 111th Annual Meeting.

4. *Resolved,* That the Association acknowledges its debt of gratitude to Dr. Daniel Blain and to Mr. Austin Davies for their never-failing services on our behalf, and to their generally unseen staffs, whose labors ensure the smooth carrying-on of the Association's business.

5. *Resolved,* That the Association is ever conscious of its indebtedness to Doctor Clarence Farrar for his long years of fruitful work as Editor of the *American Journal of Psychiatry* and for his never-ending efforts to maintain the high standards of the profession of Psychiatry.

6. *Resolved,* That the Association hereby openly expresses its appreciation to the members of the working press, who over the year and especially at the annual meeting have so fairly interpreted the aims, endeavors, and accomplishments of our profession to the American people and to the world.

7. *Resolved,* That the Association renders its thanks to the Committee on Arrangements, and to its Chairman, Dr. David J. Flicker, for the hospitality we have enjoyed during our stay in this city, a hospitality which has made our meeting pleasant and productive.

8. *Resolved,* That the Association hereby conveys to Dr. Evelyn Ivy, Chairman, and Mrs. Kenneth B. Walton, Co-Chairman of the Ladies' Committee, and to the other ladies of that Committee, its enthusiastic appreciation for the many time-consuming activities in which they have engaged to make our stay a memorable one. We also wish to make known our thanks to the Atlantic City Convention Bureau for their aid in facilitating the arrangements of this Committee.

9. *Resolved,* That the Association hereby records the debt of appreciation it owes Mr. Harold E. Baggs and Mr. Walter Hoag of the Traymore Hotel and Miss Ada Taylor of the Claridge Hotel for their success in watching over our creature comforts and in facilitating the meetings of Council, Assembly, and Committees, and to Mr. Al Skean, of the Atlantic City Convention Bureau, whose interest and work in connection with the Association was so helpful. Special thanks are also due to the Gray Audograph Corporation, whose kindness and efficiency made possible the recording of the meetings.

10. *Resolved,* That the heartfelt appreciation of the Association be again extended to the Committee on Program and to its Chairman, Dr. David Young, for the informative and challenging program which we enjoyed, and for the excellent organization of that program.

11. *Resolved,* That the warm gratitude of the Association also go to the Budget Committee, under the chairmanship of Dr. Robert Felix, whose unsung and often unappreciated efforts are here all too briefly acknowledged.

12. *Resolved,* That the Association likewise expresses its sincere appreciation to the Committee on Public Information and to its Chairman, Dr. Wilfred Bloomberg, and also to Mr. Robert L. Robinson for their successful efforts to develop a better public understanding of Psychiatry and the problems which it encounters and seeks to overcome.

13. *Resolved,* That the gratitude of the Association be expressed to Dr. Winfred Overholser, Chairman, and the members of his Special Committee for their laborious and time-consuming efforts in successfully securing a permanent home for the Association in Washington, D. C.

14. *Be it resolved,* That the Association record its great debt of gratitude to Dr. William B. Terhune and those of his Special Committee for their arduous, exacting and somewhat unpopular task of successfully raising funds for the building campaign.

15. *Resolved,* That the Association expresses its sincere appreciation to the Atlantic County Association for Mental Health for so ably sponsoring the Joint Meeting with The American Psychiatric Association on Monday evening, May 9, especially to Mrs. Russel Austin, President of the Association, and Mrs. Josiah White, 4th, Chairman of its Education Committee. Appreciation is also expressed to Drs. Jack R. Ewalt, Richard J. Plunkett, and Maurice Linden, whose addresses were so timely and appropriate to the occasion.

LIST OF DECEASED MEMBERS AS READ AT THE 1955 ANNUAL MEETING

Florence L. Meredith, Watertown, Mass. ..... Died Aug. 16, 1951
Sondra F. Bakal, New York, N. Y. ..... Died Aug. 23, 1951
Fredrich Joseph DeNatale, Poughkeepsie, N. Y. ..... Died Aug. 3, 1952
Gertrude Werner, New York, N. Y. ..... Died Oct. 31, 1952
Willis E. Merriman, Utica, N. Y. ..... Died Feb. 14, 1953
M. W. Ireland, Washington, D. C. ..... Died Feb. 14, 1953
Edson H. Steele, Los Angeles, Calif. ..... Died June 23, 1953
Henry G. Smith, Cedar Grove, N. J. ..... Died Aug. 3, 1953
Charles Arkebauer, Little Rock, Ark. ..... Died Oct. 22, 1953
Richard Binion, Milledgeville, Ga. ..... Died Oct. 28, 1953
Thomas E. Bamford, Syracuse, N. Y. ..... Died Nov. 10, 1953
Max Witte, Independence, Iowa ..... Died Nov. 12, 1953
Elizabeth Lehmer, Vinita, Okla. ..... Died Nov. 13, 1953
Raymond E. Doyle, Jefferson Barracks, Mo. ..... Died Nov. 19, 1953
William D. Partlow, Tuscaloosa, Ala. ..... Died 1953
Miguel O. de Almeida, Rio de Janeiro, Brazil ..... Died Jan. 19, 1954
Frederick F. DuPree, Knoxville, Tenn. ..... Died Jan. 21, 1954
Russell S. Wharton, Lima, Ohio ..... Died Jan. 25, 1954
Milton K. Meyers, Philadelphia, Pa. ..... Died Jan. 25, 1954
Julius Hauser, Buffalo, N. Y. ..... Died Jan. 27, 1954
Ada B. Morris, Cambridge, Mass. ..... Died Feb. 15, 1954
Alfred B. Branon, Baltimore, Md. ..... Died Feb. 28, 1954
Edwin C. McGowan, Long Beach, Calif. ..... Died Mar. 21, 1954
William V. Fittipoldi, Philadelphia, Pa. ..... Died Mar. 24, 1954
Erving Holley, East Hampton, Conn. ..... Died Mar. 24, 1954
David Kirschenbaum, Woodside, L.I., N. Y. ..... Died April 2, 1954
Charles I. Lambert, New York, N. Y. ..... Died April 18, 1954
James L. Spivey, Wichita Falls, Texas ..... Died April 19, 1954
Ambrose T. Kibzey, Pontiac, Mich. ..... Died April 25, 1954
Richard D. Lowenberg, Bakersfield, Calif. ..... Died April 29, 1954
Samuel N. Clark, Jacksonville, Ill. ..... Died May 3, 1954
James G. McKay, New Westminster, B.C., Can. ..... Died May 3, 1954
Ralph P. Townsend, Michigan City, Ind. ..... Died May 23, 1954
Sidney D. Klow, Memphis, Tenn. ..... Died May 24, 1954
Clarence P. Oberndorf, New York, N. Y. ..... Died May 30, 1954
Roy C. Young, Covington, La. ..... Died June 12, 1954
G. Kirby Collier, Rochester, N. Y. ..... Died June 18, 1954
Ralph M. Fellows, Milwaukee, Wisc. ..... Died June 20, 1954
Fred J. Conzelmann, Stockton, Calif. ..... Died June 26, 1954
F. Ross Haviland, Syracuse, N. Y. ..... Died June 27, 1954
George Fenyes, Chicago, Illinois ..... Died June 27, 1954
Arthur G. Lane, St. Petersburg, Fla. ..... Died July 20, 1954
Theodore P. Wolfe, Taos, N. M. ..... Died July 28, 1954
E. Stanley Anderson, Lima, O. ..... Died Aug. 9, 1954
Ernest E. Hadley, Washington, D. C. ..... Died Aug. 10, 1954
Ernest A. Campbell, Vancouver, B. C., Can. ..... Died Aug. 19, 1954
Ilya M. Scheinker, New York, N. Y. ..... Died Aug. 25, 1954
Margaret V. Beyers, Sykesville, Md. ..... Died Sept. 6, 1954
Charles A. McKendree, New York, N. Y. ..... Died Sept. 10, 1954
Maurice E. Hermann, Coral Gables, Fla. ..... Died Sept. 11, 1954
Louis H. Twyeffort, Bryn Mawr, Pa. ..... Died Sept. 15, 1954
Florence O. Austin, Talmadge, Calif. ..... Died Sept. 20, 1954
George W. Brown, Williamsburg, Va. ..... Died Oct. 8, 1954
Riley H. Guthrie, Bethesda, Md. ..... Died Oct. 23, 1954
Sydney G. Biddle, Philadelphia, Pa. ..... Died Oct. 29, 1954
William L. Nelson, St. Louis, Mo. ..... Died Nov. 1954
Thomas W. Hagerty, Stockton, Calif. ..... Died Nov. 9, 1954
Herbert W. Hyatt, Boise, Ida. ..... Died Nov. 10, 1954
Abraham A. Low, Chicago, Ill. ..... Died Nov. 17, 1954
Elinor M. Langton, Philadelphia, Pa. ..... Died Nov. 20, 1954
Robert J. Phifer, Woodville, Pa. ..... Died Nov. 21, 1954

John P. Howser, Las Vegas, N. M.	Died	Dec.	14, 1954
Morris Balla, South Bend, Ind.	Died	Dec.	18, 1954
Theodore G. Branfman, New York City	Died	Dec.	26, 1954
Lowell S. Selling, Orlando, Fla.	Died	Jan.	18, 1955
David S. Evans, Parks, A.F.B., Calif.	Died	Jan.	22, 1955
Orin R. Yost, Ormond Beach, Fla.	Died	Jan.	23, 1955
Robert W. Robb, Larned, Kans.	Died	Jan.	29, 1955
Arthur V. Gorton, Norwalk, Calif.	Died	Feb.	7, 1955
William H. Dunn, New York, N. Y.	Died	Feb.	12, 1955
Paul Vervaeck, Brussels, Belgium	Died	Feb.	13, 1955
Neville E. Stewart, Lakewood, Colo.	Died	Feb.	15, 1955
Charles Harry Creed, Athens, O.	Died	Feb.	24, 1955
Adolf Zeckel, New York City	Died	Mar.	17, 1955
E. Russell Jacka, Wichita, Kans.	Died	Mar.	28, 1955
Israel Straus, New York City	Died	April	4, 1955
Seymour S. Pardell, New York City		no date	

SUMMARY OF MEETINGS OF COUNCIL AND EXECUTIVE COMMITTEE MAY 1954 TO MAY 1955

In this report, an attempt is made to give a summary of the principle actions of the Executive Committee and the Council at the meetings throughout the year. Many routine matters are not reported here, such as referrals to committees which were acted upon later. Copies of the full minutes of these meetings were sent to each District Branch and Affiliate Society where they can be obtained by members of those organizations, and copies are also available in the central office in Washington.

Executive Committee Meetings, June 13 and September 25, 1954.—Directed the Treasurer to pay up to $3,800 a month through November 1, 1954, for the expenses of the C.I.B. Appropriated up to $1,500 for the Central Office to employ an expert and clerical help in connection with the program concerning psychology-psychiatry relationships. This expert has conferred at length with Dr. Huston, with the APA legal office, and with APA members in New York, and has organized and analyzed a large file of material and has prepared reports for the Committee on Clinical Psychology. Directed the employment of a person to work in the Medical Director's office, spending half his time to assist the APA Secretary. Increased the Mental Hospital budget by $1,000 to allow for hiring temporary help throughout the year, it being understood that the additional sum would derive from MHS revenues. Invited the Speaker of the Assembly to attend all Executive Committee meetings, his expenses to be paid from the Council contingency fund. Approved the expenditure of $5,000 as a deposit on the Central Office Building. Approved reimbursing Mr. Austin Davies for expenses incurred on his trip to California to assist in the organization of the West Coast divisional meeting. Directed that Dr. Douglass Orr be reimbursed for his expenses in connection with the West Coast divisional meetings, this action to establish no precedent. Granted the Medical Director sick leave with full pay until January 1, 1955, and appointed Dr. Harvey Tompkins as Acting Medical Director for that time without salary compensation, both actions becoming effective September 1, 1954. Approved $550 additional expenses for the Committee on Ethics, to come from funds appropriated for committee work. Approved payment of the expenses of Dr. David J. Flicker at the joint APA-AMA meeting with the chairmen of AMA State Committees for Mental Health, as a substitute for Dr. Barton. Appropriated $342.15 from Council contingency funds for additional expenses of the Program Committee, to allow a committee man from California to attend the fall meetings. Raised the salary of the Nursing Consultant from $5,400 to $5,700 a year as of September first. Directed that the 1955 Annual Meeting program be printed in two parts: one to consist of the program as presently prepared but without the short abstracts, this part for general distribution; the other part to consist of abstracts similar to those now prepared for the press, this part to be sold at the meeting for a low price; this method of programming to be tried for one year and then reconsidered. Decided that papers presented at divisional meetings are of a value equal to those presented at annual meetings and that therefore the same paper should not be given at both meetings, and advised that equal consideration be given such papers for publication in the JOURNAL. Heard the Treasurer report that there will be a budgetary deficit at the end of the fiscal year. Ways of instituting economies were discussed and are to be the subject of further study and implementation by the Council. Decided that the $2,500 authorized by Council for the option on the Central Office building should be considered an advance to be returned to the Treasury from the Building Fund when the purpose of the Fund is accomplished. Asked Dr. Ewalt to prepare for the JOURNAL a brief financial report pointing out that expenditures are heavy this year, but that a good proportion will be reimbursed and that the only real deficit comes from the C.I.B., the work of which is essential. Directed the formation of an *Ad Hoc* Committee from Council or ex-officio members of Council who will consider with members appointed by the Speaker of the Assembly, the manner of appointing the Nominating Committee and the manner of choosing slates of candidates for office, this committee to report to the President. Instructed the Medical Director to continue his present plans for various surveys according to his judgment. Directed the formation of a committee on ways and means of financing the C.I.B. Approved a report of the Building Fund Committee which implemented various powers already granted to it by Council, including an outline of the early stages of the program, various expenditures from its budget, and authorization of the hiring of one person and emergency help to conduct the campaign. Heard that funds were not available to make the communications study by the National Opinion Research Center, but that it would begin whenever funds could be secured. Approved a statement which Dr. Blain, with the advice of the Committee on Legal Aspects, sent to Senator Hendrickson, opposing the creation of a National Institute of Juvenile Delinquency. Following a request that the announcement of a journal be carried without charges in the Mail Pouch, decided that an exception ought not to be made in this case. Heard that a Canadian physician who had been on the rolls of a district branch without being a member of the APA was no longer a member of that district branch. Heard that the case of the member who had advertised in a foreign-language paper had been satisfactorily closed with the withdrawal of the advertisement. Received with great interest Dr. Appel's report of a meeting among Drs. Noyes, Appel, and Theodore Robie. Referred to the Medical Director and the Mental Hospital Service Consultants the whole matter of an available committee of mental hospital experts. Reaffirmed Council's

action in withdrawing from the National Health Council. Heard that local responsibility has been assumed for seeing that psychiatric help will be available to patients even in vacation time for those who need it. Approved the printing of *Standards for Psychiatric Hospitals and Clinics*, parts 1-3. Decided not to discontinue the Saturday evening meetings of coordinating committees at the fall meetings. Agreed that pharmaceutical houses should not sponsor cocktail parties at the Annual Meeting; that the Wednesday night banquet is the President's dinner and should be arranged entirely according to his judgment; and that the attention of the Program Committee should be called to the custom of holding one night open at the Annual Meeting for meetings of the national organizations which traditionally meet at the same time and place as the APA. Accepted a proposal to send through the Mail Pouch an advertising brochure on a drug. Decided that in general speeches by APA members should be matters of individual responsibility and that it would be poor policy for all public utterances to bear the Association's stamp of approval. (This position was taken upon request of a member who was reluctant to permit the use of his status as an APA committee chairman in publicizing a speech.) Reaffirmed the policy set by Council under which the present proportionate shares of the cost of publishing illustrated papers are borne by authors and the JOURNAL, and sustained the Editor's stand in a particular case.

Council Meeting, October 30-31, 1954.—Approved the foregoing actions of the Executive Committee. Directed that the usual contribution to the National Society for Medical Research be made this year. Agreed that the major responsibility for financing and organizing Divisional Meetings of the Association lies with the local groups who hold the meetings, and that although the Central Office may assist in organizing the first such meeting in each area, it should not become involved in assisting any network of such meetings. Heard reports from officers and most of the Association's committees. Established an *Ad Hoc* Committee to Review the Increasing Responsibilities of the Association. Presented Dr. Howard Potter with an inscribed silver cigarette case. Authorized the Medical Director to seek foundation support for the employment of additional expert consultants and personnel to assist in the consultation work in connection with state surveys. Selected Dr. Lauren Smith to fill the vacancy on the Editorial Board of the JOURNAL. Endorsed the program of the National Citizens Committee for Educational Television. Authorized payment of the expenses of the Central Inspection Board up to $3,800 a month until March 31, 1955, when the new budget came into effect. Asked a committee to explore, with the Joint Commission on Accreditation of Hospitals, plans for financing the work of the C.I.B., and appropriated $25,000 per annum for this work, provided the other members of the Joint Commission on Accreditation of Hospitals assume the rest of these expenses. Established a liaison relationship with the American Hospital Association, asking that consideration be given to a joint sponsorship of a research study of the design and function of existing psychiatric units in general hospitals. Approved the substance of the "Report and Recommendations on Relations with Clinical Psychology," prepared by the Committee on Relations with Psychology, and asked this committee to reply as they suggested to an inquiry on the recognition of specialists in other fields which had been received from the Secretary of the AMA Council on Medical Education and Hospitals. Appropriated $11,720 for the use of the Committee on Relations with Psychology for the period November 1, 1954, to November 1, 1955. Took steps to initiate the development of the present Joint Commission on Mental Illness and Health, and accepted an offer of $5,000 from the Field Foundation to make possible several preparatory meetings. Approved the holding of a second conference of associations interested in mental health, one-third of the expenses of this meeting outside of travel to be borne by the APA. Approved for recommendation to the membership several applications for District Branch and Affiliate Society status. Accepted a report on Blue Shield and Blue Cross plans presented by the *Ad Hoc* Committee on Economic Aspects of Psychiatry, and adopted a resolution protesting discrimination against patients with nervous, mental, or emotional disorders. Established a Standing Committee on Private Practice. Accepted the budget prepared by the Committee on Budget. Authorized the Medical Director to endeavor to secure foundation support for the continuance of the Architecture Study Project. Directed that the Freud Centenary Committee of the American Psychoanalytic Association be allowed space for its exhibit at the 1956 Annual Meeting of the APA. Approved publication of the *Outline of a Proposed Curriculum for Undergraduate Teaching in Psychiatry*, prepared by the Committee on Medical Education. Approved publication of a revised edition of the descriptive directory of psychiatric residency training programs. Approved a joint resolution of the Committee on Relations with Psychology of The American Psychiatric Association and the Committee on Relations with Psychiatry of the American Psychological Association, which sought to establish a moratorium on all legislative actions which would modify the relations between the two professions except as mutually agreed upon by the two assocations, and invited the American Psychological Association to enter into such an agreement. Authorized the Program Committee to present a television program as one of the scientific events at the Annual Meeting. Authorized certain expenditures of the *Ad Hoc* Committee to Negotiate for the Permanent Home. Established an *Ad Hoc* Committee to study the proposal for the establishment of a Psychiatric Research Fund with APA participation.

Executive Committee Meetings, December 15, 1954, January 9, February 20, 1955.—Authorized the Medical Director to spend up to $1,000 for professional assistance in processing this year's applications for Membership and Fellowship. Authorized the expenditure of a sum up to $1,000 for re-organ-

izing the records of the Mental Hospital Service. Authorized the expenditure of a sum up to $300 for the expenses of the Committee to Review the Increasing Responsibilities of the Association. Empowered the Committee to Negotiate for a Permanent Home to acquire for the Association the property at 1704 18th Street, N.W., Washington, D. C., at a cost not to exceed a net total of $110,000 and empowered them to arrange the terms of payment, with the Medical Director participating in the negotiations. Authorized the Committee on Relations with Psychology to send out from time to time reports to the membership on current progress, through the Mail Pouch, Newsletter, etc. Decided to hold the 1955 Fall Council-Committee Meetings at the Woodner Hotel in Washington, D. C., on November 3-6, 1955. Authorized the Medical Director, the Executive Assistant, and the Public Information Officer to sign contracts for the sale of books and services. Directed that in the present state of stringency of funds, the co-ordinating committees be limited to the amounts assigned them in the budget, with the chairmen of the co-ordinating committees being allowed latitude enough in deciding how these funds shall be expended. Granted permission for *Current Medical Digest* to reprint an excerpt from *The Psychiatrist, His Training and Development,* provided the editors of the book approve the request. (Such approval was subsequently given by the editors.) Directed that the APA not participate in the functions of the International Science Foundation at this time. Instructed the Medical Director, in co-operation with the Chairman of the Committee on Research, to make arrangements with the Ciba Company for subsidization of the proceedings of Regional Research Conferences, and later heard that arrangements had been completed, and publication would begin. Approved a report of the Chairman of the Co-ordinating Committee on Technical Aspects that it would be unwise to establish formal relationships with any music therapy groups, and that the Committees on Therapy and Research could keep in touch informally with any therapy groups which desire such contact. Established a liaison relationship with the American Academy of Pediatrics. Approved in principle the sponsoring by the Association of properly supervised and properly controlled television and radio programs, and directed and empowered the Medical Director and the Committee on Public Information to negotiate with suitable producers or firms, and authorized them to enter into contractual relations for the production of television or radio programs. Approved a statement by the Committee on Relations with Psychology embodying the following five points necessary for a satisfactory bill for the certification of psychologists: (1) The purpose of a certification bill is to designate, by issuance of certificates to qualified persons, who shall have the right to use certain professional titles, such as "certified psychologist," or "psychologist." (2) The law need not differentiate subspecialties of psychology. (3) The examining board should be composed of psychologists. (4) The law should not include a definition of the practice of psychology. Such a definition is necessary in a licensure bill. It is not necessary to a certification bill, and its presence may make such a certification bill equivalent to licensure. (5) The law should include a clause such as: "Nothing in this act shall be construed to give the right to engage in the practice of medicine, or any of the other healing arts, as these are defined in the laws of this State."

Directed that certain publications of the American Psychological Association be distributed through the Mail Pouch for the information of APA members, with a covering statement to be formulated by the Committee on Relations with Psychology. Favored holding a conference of specialty groups to consider the matter of certification of subspecialty groups, and directed that this position be transmitted to the Secretary of the American Board of Psychiatry and Neurology in answer to his inquiry as to the attitude of the APA on such certification. Authorized the Chairman of the Program Committee and the Medical Director to complete arrangements for a closed-circuit television program at the Annual Meeting. Directed that certification by the Committee on Certification of Mental Hospital Administrators be indicated in the Membership Directory by a special symbol. Directed the Executive Assistant to proceed for the present with the membership directory as he proposes. Certified the procedure for dropping members who have not paid their dues for three successive years. Authorized the Medical Director to accept advertising matter for distribution in the Mail Pouch at his discretion. Approved four recommendations offered by the *Ad Hoc* Committee on Financing the C.I.B., following a meeting with the Joint Commission on Accreditation of Hospitals, as follows: (1) That the APA continue with its detailed consultation surveys until all the state and private hospitals have been completed, and try to work out arrangements for inspecting the Veterans Administration hospitals; (2) That 100% of the cost of these surveys be charged, although not retroactively where a contract is in effect; (3) That Dr. Chambers (for the APA) and Dr. Anderson (for the Jt. Commission) jointly execute a C.I.B. inspection of a mental hospital and a Jt. Commission inspection of a general hospital and report back to their respective bodies; (4) That the *Ad Hoc* Committee then meet again with the Jt. Commission and bring back recommendations as to the fruitfulness of working with the Joint Commission of Accreditation of Hospitals for the succeeding follow-up and maintenance inspections.

Directed that all APA participation in the Second International Congress for Psychiatry be carried on without additional expense to the Association. Increased the revolving fund for "Publications" to $10,000, so that large orders for certain publications might be filled. Rescinded the action by which Council had established the system of volunteer nonvoting affiliate membership on committees. Authorized the President to appoint consultants to assist the Medical Director in the State Survey program, without expense to the Association. By mail vote of Council, named Chicago, Illinois, as the place for holding the 1956 Annual Meeting, April

30-May 4. Heard from the Acting Medical Director that the following grants had been received from Foundations: $18,000 from the Lasker Foundation for the employment of personnel for the state surveys; $5,000 from the Field Foundation for preliminary work in connection with a nation-wide survey of mental illness; $8,000 from various foundations for a public-relations conference project. Suggested the name of Dr. Noyes as the subject for a series of magazine articles on the work of a representative psychiatrist. Decided that a certain portion of the Annual Meeting time should not be exempted from the administration of the Program Committee, and that it seems best to leave the Committee's powers undiminished by special exceptions. Directed that the budgetary sources for the expenses of official representatives of the APA to meetings of other organizations should be specifically decided at the time such representation is authorized, and felt that when appointments are made between meetings of the Executive Committee, the President shall decide the budgetary source by correspondence with other members of the Executive Committee. Receive a request from the Committee on Medical Education concerning the extent of APA representation on the American Board of Psychiatry and Neurology; (One of the members of the Executive Committee offered to speak to the members of the Board as an individual.) Decided that no conflict existed with National Health Week warranting a change in the dates of the 1955 Annual Meeting. Was informed of the donation of a book to the Building Fund by Dr. John Bostock, APA Corresponding Fellow of Brisbane, Australia. Gave Dr. Dale C. Cameron official status as APA representative at a joint meeting in January of the APA Committee on Industrial Psychiatry, the AMA Council on Industrial Health, the Board of Directors of the Industrial Medical Association, and the Academy of General Practice, at no additional appropriated expense to the Association. Asked Dr. Bloomberg to write the Editor of *Collier's Magazine*, pointing out that the Committee on Public Information stands ready to advise on articles involving psychiatry, and agreed that an article in the Newsletter should call attention to the services made available to APA members by the Committee. Heard the Acting Medical Director report that a meeting of the *Ad Hoc* Committee on Financing the C.I.B. with the AMA Council on Mental Health had been exploratory and had not resulted in any specific recommendations. Directed that the Committee on Certification of Mental Hospital Administrators not be incorporated. Approved a tentative program and statement of policy for the 1955 Council-Committee Meetings. Decided not to pursue a proposal that arrangements be made for the AMA Council on Pharmacy and Chemistry to create a special division to study drugs used in psychiatry. Referred to Dr. Appel for his files a letter from Dr. John Ernst on the importance of psychoanalysis in any national survey of mental illness and health. Appointed Dr. Leo Bartemeier the official APA delegate to the unveiling of a memorial to Freud in Vienna in February, at no cost to the APA. Considered current legislation in the Congress and its implications for psychiatry, at a special meeting on February 19. (Various guests explained the administration's legislative proposals, but since the meeting was for information and discussion only, no actions were taken.) Was informed that, as a result of a letter sent by Dr. Noyes to the President of the AMA, it seems that the APA will be able to secure legal assistance from the AMA and that the AMA Council on Mental Health is willing to consider again certain aspects of the question of certification of clinical psychologists in the light of recent developments. Decided to suggest that an article on the organization and aims of the World Federation of Mental Health be carried in the Newsletter, in lieu of distributing certain WFMH material in the Mail Pouch. By mail vote, authorized the President to appoint representatives to the Royal Medico-Psychological Association meeting in Dublin and the International Congress of Criminology meeting in London this summer and fall. Established an *Ad Hoc* Committee of four, including the Medical Director and the Executive Assistant, to study the entire matter of the Membership Directory.

Council meetings, May 7, 8, and 12, 1955.—Approved the foregoing actions of the Executive Committee. Heard reports from officers and most of the committees of the Association. Expressed pleasure at the return of Dr. Daniel Blain to his office, and thanked Dr. Harvey Tompkins for his labors as Acting Medical Director. Accepted with thanks the offer of the Smith, Kline and French Foundation of $30,000 a year for three years to establish a post-graduate fellowship training program in psychiatry, and established a board to administer this grant. Accepted the offer of $10,000 from three members of the Association to establish a memorial, the Executive Committee to work out satisfactory details. Directed that Annual Meetings be scheduled for the last full week in April, beginning with the earliest possible year. Approved a statement distinguishing among "area," "divisional," and "regional" as applied to various kinds of peripheral meetings of the Association. Approved for recommendation to the membership several applications for District Branch and Affiliate Society status. Ratified the action of the Treasurer in taking out various forms of insurance on the new Central Office Building. Took appropriate action on several matters of ethics. Approved with certain modifications the recommendations of the Membership Committee for acceptance into the various classes of membership, etc. Recommended to the membership the adoption of an amendment to the By-Laws which would make possible the induction of new Fellows at the Annual Meeting of their election. Thanked Drs. Young, Duval, and Bloomberg for their work on their committees over the past years. Authorized publication of the *Psychiatric Glossary*. Approved the actions of the Executive Committee in connection with the production of a series of television programs, and approved the recommendations of the Committee on Public Information dealing with this matter. Nominated Dr. David A. Boyd,

Jr. for reappointment to the American Board of Psychiatry and Neurology. Heard that the property at 1794 18th Street, N.W., Washington, D. C., had been bought at a final price of $105,000. Established a Standing Committee on the Central Home, with authority also to carry on alterations and development of the newly acquired home in Washington. Directed that the Chief Inspector of the C.I.B. shall be a member of the *Ad Hoc* Committee on Financing the C.I.B., and decided that overhead shall be included in the charges made for inspecting and rating. Endorsed the Banks-MacDermott Plan for permanent life insurance, designed and underwritten by the Jefferson Standard Life Insurance Company of Greensboro, N. C. Agreed to participation of APA Fellows and officers in the administration of the Psychiatric Research Fund as provided by the regulations of that Fund. Accepted the report of the *Ad Hoc* Committee on Non-Medical Specialists, which recommended the holding of a conference of branches of medicine concerned with non-medical specialties for the purpose of formulating a more comprehensive statement upon the recognition of other specialists and the need for collaborative action. Directed that there shall be Canadian representation on the Central Inspection Board and the Board of Consultants of the Mental Hospital Service, and that the President shall request from the Canadian Psychiatric Association the submission of two or three names for each such position. Named Dr. Raymond Waggoner as APA delegate to the University of Michigan's 8th Conference on Aging. Adopted a revised budget for the Mental Hospital Service, directed that if funds can be found for this purpose, a Deputy Medical Director may be employed at any time. Approved two small increases in salary for C.I.B. personnel. Took no action upon lump sum prepayment of lifetime membership dues. Directed that the office of the Nursing Consultant be discontinued after October 31, 1955. Approved several changes in the Procedural Code of the Assembly of District Branches. Authorized the holding of a Northeast Divisional Meeting in 1956. Changed the regulations of the Committee on Certification of Mental Hospital Administrators to remove the requirement that applicants for certification be Fellows of the APA, and to re-word the requirement for "adequate training in psychiatry, or neurology, or both," to read "adequate training in psychiatry." Granted permission for distribution through the Mail Pouch of a sheet of information on the Second International Congress of Psychiatry. Approved preliminary steps of the Committee on Research for the publication of the Proceedings of Regional Research Conferences. Designated the Sunday evening before the Annual Meeting for simultaneous individual meetings of all committees. Discontinued the holding of committee meetings open to the general membership (upon request of the committee chairmen). Directed that a conference of the chairmen of the co-ordinating committees be given a place on the regular program at the Annual Meeting. Designated the Secretary as formal liaison officer between the Council and the APA staff. Recommended to the membership that the Association support Senate Bill 849 for federal aid in constructing medical research facilities. Named Drs. John J. Madden of Chicago and Frank M. Gaines of Louisville to the Committee on Membership. Continued various *Ad Hoc* committees. Thanked Dr. Ralph Chambers for his long and faithful services to the Central Inspection Board and expressed its sincere regret that he is leaving.

REPORT OF THE TREASURER
APRIL 1, 1954—MARCH 31, 1955

The financial operations of the Association in this year reflect a great expansion of worthwhile activities. The accounts were audited by Wilbur D. Tripp and Company, 271 Madison Avenue, New York, N. Y.

We have asked for appointment of a House Committee to manage the new home. Plans are made for outside financial aid in the Joint Commission's activities. This Commission was started by The American Psychiatric Association and the Council on Mental Health of the American Medical Association. Council has asked the budget committee to provide for additional aid to the Medical Director, and to consider further the establishment of personnel policies, including step-rate increases and some type of pension and retirement funds for the permanent employees of the Association.

A summary of the financial statement is as follows:

General Fund Summary	
Income	$378,729.85
Expenditures	405,444.65
Excess Expenditure over income in general account	26,714.80
Investments:	
Book Value	74,015.87
Market	95,410.50
Actual increase in value	21,394.63
Building Fund Summary	
Cash Income (pledges not included)	99,507.56
Expenditure ($20,000.00 option and down payment)	26,809.71

Restricted Funds

A—Commonwealth Fund Grant	1,216.46
B—Conference For Psychiatric Nursing Consultants	1,023.93
C—Contract Survey—Lasker Grant	5,738.31
D—Hospital Architecture Study Account	54,700.41
E—Joint Commission Account	4,649.41
F—Public Relations Conference Project	7,633.88
G—Regional Research Conference Project	2,996.59

JACK R. EWALT, M. D.,
Treasurer

REPORT OF THE COMMITTEE ON BUDGET

To the President and Members of Council:

Your Committee on Budget met on May 10, 1955, to consider matter referred to it relative to the Budget of the Association, and submits herewith the following report.

As has been reported to you by the Treasurer, the expenditures for the previous year were $26,714.86 in excess of income. The budget adopted by Council in October 1954 anticipates a deficit of $33,768.00 for the current year. It will be recalled that the original budget submitted by this Committee would have balanced expenditures with anticipated income. Council, however, instructed its Committee to prepare another estimate which would contain expenditures in excess of income in the amount mentioned above. In addition, Council authorized expenditures totalling $3100. Thus the anticipated deficit for the current year is $36,868, at the present time.

Your Committee feels it is its duty to again remind Council that the resources of the Association are being rapidly depleted. It will be necessary to liquidate some of the securities held by the Association to meet this deficit. Your Committee is strongly of the opinion that our financial situation is not a favorable one and that if Council does not soon come to grips with the very pressing problem of balancing the budget the already dwindling reserves of the Association will become exhausted.

In view of this depressing situation, your Committee submits the following recommendations:

1. APPROPRIATIONS

A. *Mental Hospital Service and Institutes.*—It appears that revenue for advertising will be significantly more than was anticipated in October. It is therefore recommended that the attached revised budget for Mental Hospital Service and Institutes be adopted. This authorization will increase expenditures by $4,350 which is offset by estimated additional income of $4,500.

B. *Central Inspection Board.*—It is recommended that the attached itemized budget for the Central Inspection Board be adopted. It is necessary for proper auditing of the books that items of expenditures be properly identified. This itemized budget anticipates income to the Board, from all sources, of $46,100 of which a sum not exceeding $25,000 comes from the A.P.A., and would authorize expenditures totalling $46,100.

2. ASSISTANT TO THE MEDICAL DIRECTOR

As directed by Council, this matter was seriously considered by the Committee, but in view of our present financial situation, we can see no way to add this person to the Staff of the Association without incurring a greater deficit. We therefore recommend no appropriation for this purpose.

3. LUMP SUM APPROPRIATION FOR CERTAIN ACTIVITIES OF THE ASSOCIATION

This matter was discussed at some length as requested, but because of the necessity for being able accurately to identify items of expenditures for auditing purposes, your Committee recommends against this procedure.

4. LUMP SUM PAYMENT OF LIFE MEMBERSHIP DUES

Your Committee finds it impossible to submit a recommendation at this time for the following reasons:

(a) Further information is needed regarding the possibility of increasing membership dues. A firm figure is needed in order to calculate the amount of lump sum payments at various ages.

(b) For what classes of membership should this privilege be available? If for Members and Associate Members as well as Fellows, it might serve as a deterrent to advancement of members to a higher category of membership. If one can make a lump-sum payment at the rate set for a Member, it is not likely that many would later desire to advance to Fellow and again pay dues. It seems to your Committee that the best procedure would be to limit this primarily to Fellows.

(c) Lump sum payments are usually set at a figure which effects some financial savings to the member. At the present time, the Association is in no position financially to offer such savings to its members.

(d) For what purposes would money so acquired be used? Would it be invested for the Association so that its earnings will be available for such purposes as the Association may see fit; or would these funds remain in the General Account? In the latter

case, the Association might soon find itself in an even more serious financial situation, since anticipated income would be reduced in the years to come and the revenues from the larger immediate payments would have been expended.

5. NURSING SERVICE

It seems to your Committee that this activity of the Association is one which belongs primarily to the nursing organizations, and is one in which these organizations are showing a high degree of interest. Also, in the minds of the Committee, there is great doubt as to the urgency with which the membership desire the continuation of this activity by the Association. Finally, the funds saved by the elimination of this activity will contribute considerably to the reduction of our steadily mounting deficit.

Your Committee recommends, therefore, that Council instruct it not to budget for this activity in the coming year.

6. CENTRAL INSPECTION BOARD

Your Committee feels, as it is sure all members of the Association feel, that the Central Inspection Board has played a great role in the improvement of our mental hospitals. Had this not been so, some of our financial problems would have been simplified. For several years Council has been aware of the financial drain of the Central Inspection Board on the Association, yet because of the importance of the work of the Board, this drain was allowed to continue. The time has now come, however, when some kind of positive action must be taken.

The problem, as seen by your Budget Committee, is simply this:

The Association is depleting its reserves at an alarming rate. Unless steps are taken very soon to stop the present trend, the reserves will be entirely depleted. When this time comes, the Association has not only lost these assets but also will be deprived of their earnings which this last year amounted to about $6,000.

The present activities of the Association require a spending rate in excess of income.

Council must decide which activities of the Association to curtail or eliminate so that a total savings of about $37,000 to $38,000 can be effected. This decision is inescapable and must be made at an early date. Within two years at the present rate, the reserves will be exhausted.

The Central Inspection Board is responsible for the largest net expenditure of any single operation of the Association. In the Budget Recommendations contained in this report, those regarding the Central Inspection Board contain a contribution of $25,000 from the A.P.A. funds, thus the A.P.A. stands back of the entire expenditure of $46,100 since these are authorized appropriations of the Association.

Your Committee therefore again recommends as emphatically as it is capable of doing that Council very quickly resolve the problem of the Central Inspection Board; or instruct the Committee on Budget as to what other activities it desires to reduce or eliminate.

WINFRED OVERHOLSER, M. D.,
F. W. PARSONS, M. D.,
CHARLES R. STOGHILL, M. D.,
ALFRED P. BAY, M. D.,
ROBERT H. FELIX, M. D., *Chairman*,
JACK R. EWALT, M. D., *Ex-officio*.

MENTAL HOSPITAL SERVICE AND INSTITUTES

Passed by Budget Committee, November 1954		Increase	Requested Revisions, May 1955
Subscriptions to Service	$30,000	....	$30,000
Sale of Publications	6,000	....	6,000
Advertising	1,500	....	6,000*
Mental Hospital Institutes	15,000	....	15,000
Reimb. Arch. Study Proj. for Salary Item	...	....	...
Contribution from Division Fund	1,000	....	1,000
	$53,500		$58,000
A. *Salaries*			
Service Advisor	1,000	....	1,000
Chief, Editorial Department	5,250	....	5,250
Editorial Assistant	3,800	200	4,000*
Advertising and Administrative Assistant	3,550	450	4,000*
Office Assistant (accounts)	2,800	....	2,800
Telephone Operator	200	....	200
Typist for Magazine	2,300	500 For part-time help (college boys)	2,800*
Allowed for reallocation of salaries	...	1,000	1,000*
	$18,900		$21,050

B. *Office Expenses*			
Rent	$1,500	....	$1,500
Mental Hospital (Magazine)	10,000	....	10,000
Postage	1,000	....	1,000
Supplementary Mailings	2,000	....	2,000
Office Equipment	500	....	500
Supplies	750	....	750
Miscellaneous	1,000	....	1,000
Stationery	...	....	...
Advertising	1,000	....	1,000
Film Service	2,500	....	2,500
Telephone and Telegraph	500	....	500
Travel	1,000	$850	1,850*
Printing and Distributing Other Pubs.	2,500	1,000	3,500
Promotion (membership)	...	....	...
Mental Hospital Institute	10,000	....	10,000
Contingent	500	350	850*
	$34,750	$4,350	$36,950
Grand Total: Mental Hospital Service	$53,700		$58,000

* Requested revisions or additions.

CENTRAL INSPECTION BOARD

Salaries		
Chief Inspector	$16,500	
Inspector	13,200	
Statistician	4,800	
Clerk-Typist (service)	3,600	
Telephone Operator (part time)	200	
	38,300	$38,300
Rent	1,140	
Travel	2,000	
Printing	2,500	
Communications	575	
Office Supplies	425	
Office Equipment	150	
Board Expense	225	
Clipping Service	175	
Social Security Tax and Insurance	500	
Contingency	110	
	7,800	7,800
		$46,100

COUNCIL ACTIONS ON REPORT OF THE COMMITTEE ON BUDGET

1. Appropriations:
   A. Mental Hospital Service and Institutes: *Passed*
   B. Central Inspection Board: Recommit to Budget Committee. Budget Committee to work out jointly with CIB a firmer and more business-like budget with idea that 100% of cost of CIB be covered by fees.
2. Assistant to the Medical Director: *Passed* Budget Committee to take this up at next meeting and try to work it in. Principle of an assistant to Medical Director still stands.
3. Lump sum appropriation for certain activities of the Association: *Passed*
4. Lump sum payment of life membership dues: No action needed—report received. No instructions to explore further.
5. Nursing Service: *Passed*
6. Central Inspection Board: *Passed.* Committee directed to bring in a series of alternatives which will balance the budget. Meet with Tompkins *ad hoc* committee on increasing responsibilities of APA and Blain to do this job.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC.

In conformance with the request of The American Psychiatric Association, the American Medical Association, and the American Neurological Association, we are submitting the following account of the activities of the American Board of Psychiatry and Neurology, Inc., since the last report to the Associations by letter dated February 25, 1954.

The Board consists at present of the following members:

Appointed by the American Psychiatric Association:

Dr. David A. Boyd, Jr., (term expires December 1955)

Dr. C. H. Hardin Branch (term expires December 1958)

Dr. Henry W. Brosin (term expires December 1957)

Dr. William Malamud (term expires December 1956)

Appointed by the American Neurological Association:

Dr. Bernard J. Alpers (term expires December 1955)

Dr. Knox H. Finley (term expires December 1957)

Dr. Francis M. Forster (term expires December 1956)

Dr. Paul I. Yakovlev (term expires December 1958)

Appointed by the Americal Medical Association:

Dr. Russell N. DeJong (term expires December 1958)

Dr. Francis J. Gerty (term expires December 1955)

Dr. Frederick P. Moersch (term expires December 1956)

Dr. George N. Raines (term expires December 1957)

At the annual meeting of the Board in December, 1954, the following officers were elected: Dr. Bernard J. Alpers, president; Dr. Francis J. Gerty, vice-president; Dr. David A. Boyd, Jr., secretary-treasurer.

When the Board met in Chicago, Ill., in May, 1954, 227 candidates were examined. Of this number, the Board certified 119 in Psychiatry, 9 in Neurology and Psychiatry.

The annual meeting of the Board was held in New York City in December 1954. At this time, 277 candidates were examined by the Board. Of this number, 146 were certified in Psychiatry, 9 in Neurology, and 2 in Neurology and Psychiatry.

The Board conducted an examination in New Orleans, La., on February 28, and March 1, 1955, at which time 208 candidates were examined. The Board certified 98 in Psychiatry, 12 in Neurology, and none in Neurology and Psychiatry.

Since its inception, the Board has received 7,421 applications. Some of these are still under consideration. The total number of diplomas issued by the Board to date is 5,198. Of this number, 3,903 are certified in Psychiatry, 332 in Neurology, and 963 in Neurology and Psychiatry.

DAVID A. BOYD, JR., M. D.,
Secretary-Treasurer

SPECIAL ANNOUNCEMENT

1956 PROGRAM ANNOUNCEMENT

The Committee on Program invites the submission of material for presentation at the Annual Meeting in Chicago, Illinois, April 30-May 4, 1956.

Abstracts of papers should be submitted in the following form:

1. Proposed title
2. Purpose or aim
3. Method
4. Scope
5. Findings
6. Conclusions

and may be sent to any member of the Committee.[1] Descriptions of films should be sent to Dr. Hugh T. Carmichael. Requests for roundtables should include proposed title and possible participants.

The deadline is October 26, 1955, and applies also to Sections and Committees.

The Committee wishes to thank all participants in the Atlantic City Meeting.

Hugh T. Carmichael, M. D.,
Travis E. Dancey, M. D.,
Francis J. Gerty, M. D.,
Margaret Gildea, M. D.,
Maurice Greenhill, M. D.,
William A. Horwitz, M. D.,
Zigmond M. Lebensohn, M. D.,
Martha G. W. MacDonald, M. D.,
Titus H. Harris, M. D., *Chairman.*

Section on Psychoanalysis: Chairman, Lewis L. Robbins; Secretary, Douglas D. Bond; *Section on Convulsive Disorders:* Chairman, Hans Strauss; Secretary, Andre A. Weil; *Section on Private Practice:* Chairman, Leo Alexander; Secretary, John D. Moriarty; *Section on Legal Aspects:* Chairman, Gregory Zilboorg; Vice-Chairman, E. C. Rinck; Secretary, Rupert Chittick; *Section on Psychotherapy:* Chairman, Jules H. Masserman; Secretary, Jacob L. Moreno; *Section on Mental Hospitals:* Chairman, Harrison Evans; Vice-Chairman, J. O. Cromwell; Secretary, Rupert Chittick; *Section on Child Psychiatry:* Chairman, Milton Kirkpatrick; Vice-Chairman, Paul L. Schroeder; Secretary, Leonard H. Taboroff.

[1]Abstracts of papers may also be submitted to the officers of the appropriate Section by October 1, 1955, to give them some choice in preparing their program for review by the Committee on Program.

The Aims of the Committee on Program

1. A well-rounded program, including different areas of psychiatry and different schools of thought.

2. An up-to-date program, with a preference for new material, or for older subjects, if these were not recently covered at an A.P.A. Annual Meeting.

3. Papers of scientific value.

4. Consideration for our audience by setting limits to the length of papers, number of papers given in any one section, and the time allowed to one section.

5. A General Session of wide interest.

6. Representation of different sections of the country among the authors, and official discussants.

7. An opportunity for younger authors, and some rotation among the members of the privilege of appearing on the Program.

8. The selection of official discussants, according to ability, acquaintance with or interest in the special subject; if possible with different views from the author and from a different city.

Titus H. Harris, M. D.,
Chairman.

OFFICIAL REPORTS

ASSEMBLY OF DISTRICT BRANCHES

Report of the Speaker—May 9, 1955

Fortunately for this Association, the need for more widespread participation of the membership in the affairs of the Association was recognized by your Past Presidents and Council members several years ago. As a result of this discernment and foresight, constitutional amendments were recommended and approved by yourselves for the establishment of District Branches and an Assembly of District Branches of this Association in order that you personally could make your wishes and needs known through your respective District Branch and its Delegate to the Assembly.

The first District Branches were formed in 1952 and the first Assembly of the District Branches of The American Psychiatric Association convened in Los Angeles in May of 1953. The first Speaker, Dr. Joseph L. Abramson, presided over the activities of the Assembly for the first year and your present Speaker has had this honor for the second year, now coming to a close.

There are now 23 active District Branches and the applications of additional ones will be voted on by you later in this annual meeting.

As members of The American Psychiatric Association, you have also approved an amendment to the constitution which will permit matters concerning the welfare of the Association to be initiated by the Assembly and referred to Council. Despite this machinery, established to obtain "grass roots" participation in the affairs of the Association, far too few of our membership have used this machinery. Those who have used the District Branches, their delegates, and the Assembly have been responsible for changes and achievements which have benefited all of us.

In 1952, the Council asked opinion of the Assembly as to whether multiple nominations for officers of the Association should be made by the Nominating Committee. We are very happy to inform you that the Assembly of District Branches has asked that this be done, a special committee of Council has concurred, and this year you have voted for the election of 3 Councillors from a nominating slate of 6. On behalf of the Assembly and for myself I must express appreciation for the assistance and open-mindedness of the Nominating Committee in this regard.

Other accomplishments for the past year have included the adoption of a Procedural Code, subsequently approved by Council, for the conduct of the business of the Assembly, the accreditation of delegates and recognition of privileged guests.

One of the other significant achievements of the Assembly has been to divide the Association into geographical areas, with a representative from each area in turn elected by Delegates of that area. These area representatives and the officers of the Assembly, speaker, deputy speaker and recorder, constitute a Policy Committee for the purpose of transacting the business of Assembly between formal meetings of that group.

Another important accomplishment of the Assembly has been to provide for proportional representation for voting purposes of Delegates to the Assembly. The Assembly has adopted, and the Council has approved, the resolution that proportional representation in each District Branch be based upon one vote for each 20 members, with fractions of 20 members not to be counted, and that each District Branch will be represented by one delegate who will cast the total votes allotted to his District Branch.

The Assembly has assisted in the establishment of divisional meetings of the Association. This year a meeting will be held in San Francisco, at the St. Francis Hotel, October 27 through 30, inasmuch as the annual meeting this year is being held on the East Coast. All members are invited

regardless of location. Preliminary negotiations are also under way for a divisional meeting in the autumn of 1956.

By Executive Committee action, the Speaker of the Assembly has been invited to attend Executive Committee meetings, and to address the membership at this time.

At the close of my term as Speaker of the Assembly of District Branches, it is a most pleasant obligation to acknowledge the assistance, suggestions, and actual work performed by the officers of The American Psychiatric Association, the staff of the Central Office and the Executive Assistant, the delegates, the members of the Policy Committee, and above all, the membership of the various District Branches.

I am sure you will be gratified and encouraged to know that the Deputy Speaker of the Assembly, who automatically becomes Speaker at the close of this meeting, is Dr. Addison M. Duval who will, I am sure, receive the same fine cooperation and assistance that you have accorded me during my incumbency.

C. N. Baganz, M. D.

COMMENT

THE CLOSING OF BUTLER HOSPITAL

In the year 1944 when The American Psychiatric Association was celebrating the first hundred years of its existence, historic Butler Hospital was also observing its centennial year in Providence, Rhode Island.

Now, after one hundred and eleven years of splendid service, Butler Hospital must close its doors.

At the centenary celebration the newly elected president of the Corporation of Butler Hospital, Mr. Walter A. Edwards, recalled that the donors and founders had insisted that the hospital should be established "on a firm and permanent basis" and that it should be "at least equal to kindred institutions in other states." In the commemorative volume, "A Century of Butler Hospital," William Greene Roelker, Director of the Rhode Island Historical Society, gave a detailed history of the hospital and its services under a distinguished line of superintendents beginning with Isaac Ray. Mr. Roelker's story would have gratified the Founders and satisfied them that their hospital had more than fulfilled their hopes and expectations.

However, providing superior service is one thing and paying for it is another. The inflation following the two world wars had played havoc with the hospital finances and for some years the institution has been operating in the red. The average annual deficit for the period 1941-1945 was slightly more than $6,000. By 1950 it had reached $56,000. The deficit for 1954 exceeded $127,000. With the most efficient management possible the hospital, dependent for income on patients' pay and private donations, could not cope with mounting costs of operation. Increased charges for patients could not keep up with the rising cost of their care which in 1954 was nearly 21 dollars a day per capita.[1]

The increases in patients' rates that had already been made had resulted in fewer admissions. In the case of male patients the competition of Veterans Administration hospitals tended in the same direction. In addition, the increasing psychiatric services in general hospitals and the newer treatment methods as well as various preventive measures taken together had kept out of hospital numerous patients for whom inpatient care would otherwise have been necessary. The officers of the Corporation were forced to the conclusion that the operation of Butler Hospital as a private institution was no longer practicable.

In their extremity the Board of Trustees turned to the state government and made an offer to turn the institution over for operation as a special state hospital facility. Rhode Island has a single public mental institution, the Howard State Hospital. Here 3,450 patients are cared for at an annual cost of about $4,000,000. It was considered that the estimated additional cost of upwards of $1,000,000 to operate Butler as a state facility was prohibitive. Extensive improvements and new construction presently under way at Howard together with expansion of teaching facilities will compensate in some measure for the losses to the City of Providence, to the State of Rhode Island and far beyond, incident to the closing of Butler Hospital.

It is heartening to note that Superintendent Babcock and his board, who have struggled valiantly against overwhelming odds, are studying plans whereby the existing assets of the Corporation may still be used to continue in some manner the type and standard of work for which their hospital has stood for a century and a decade and a year, writing thus a significant chapter in the history of American psychiatry.

[1] An item in a pamphlet issued by the Board of Trustees at the opening of the hospital a century ago is of interest. The trustees assured the public that charges for patients would not be more than 3 nor less than 2 dollars per week, for which "the person receives not only food and lodging, but washing, mending, light, warmth, medical attendance, and the means of employment. . . ." The trustees added that when the patient receives all this for no more than 3 dollars per week, "it cannot be regarded as high."

NEWS AND NOTES

Dr. Hoch Directs N. Y. State Mental Health Services.—The appointment of Dr. Paul H. Hoch, principal research psychiatrist at New York State Psychiatric Institute, New York City, to the post of Commissioner, Department of Mental Hygiene at Albany, cannot but be gratifying to all who are interested in the warfare against mental illness; and that should mean everyone since mental disorder is not only the greatest and most baffling public health problem but also the most costly.

The appointment of Dr. Hoch is especially gratifying as he is one of America's ranking psychiatrists, and more especially still because his conspicuous talents have been directed mainly to the field of research.

In accepting this appointment he has indicated that his efforts will continue to be focussed on this field on a state-wide plan and on preventive measures in psychiatry. He is particularly interested in the extension of psychiatric facilities in general hospitals and of community mental health clinics. A special concern is the high relapse rate of patients who, after treatment, leave the hospital in a relatively good condition, but lack facilities for treatment outside. If such facilities were available the number of readmissions to hospital could be reduced. This would be not only in the interest of patients' health but would help to relieve overcrowding in the hospitals.

Dr. Hoch is a man of wide and valuable experience and handles several languages. He had served on the medical faculties of Göttingen and Zurich—having been graduated in medicine from the former university—before coming to New York.

Both Dr. Hoch and the New York State Department of Mental Hygiene are to be felicitated on this appointment.

Bulletin of the Isaac Ray Medical Library.—With the January-April issue of the *Bulletin*, being numbers 1 and 2 of Volume 3, publication of this historical document is discontinued as announced by Editor Henry H. Babcock and his board.

Especial attention is drawn to this number of the *Bulletin* because of its unusually important content. It consists of a single article by Manfred Bleuler (76 pages of text plus a 58-page bibliography) titled "Research and Changes in Concepts in the Study of Schizophrenia." It is reprinted from *Fortschritte der Neurologie Psychiatrie und ihrer Grenzgebiete.*

Beginning with Kraepelin's formulation of dementia praecox as the starting point of the modern study of this morbid mental process, Bleuler indicates that up to 30 years ago, "there was still a common understanding, on the basis of certain fundamental concepts which were shared by everyone. Today the trend of scientific thought, the sphere of scientific interest, and scientific nomenclature have grown so far apart and become so independent within the various schools of thought and countries that even acknowledged authorities on the subject are at times no longer able to communicate with each other." Such is the confusion in psychiatry today!

M. Bleuler takes up the concept of schizophrenia ennunciated by his father, Eugen Bleuler, professor of psychiatry at the University of Zurich and whom he himself succeeded to that chair. He traces contributions by the several research disciplines—genetics, pathological physiology, neuroanatomy and neurology, clinical endocrinology, psychology, and sociology. There follow sections on course prognosis and treatments. In a concluding page the author summarizes findings. They have undone many older concepts without putting much in their place. "It seems as if the coming years will be predominantly dedicated to the investigation of those older concepts of schizophrenia which have seen the schizophrenia, primarily if not entirely, an individual disturbance of the adaptation to the difficulties of life."

This detailed review by M. Bleuler is valuable for reference and appropriately distinguishes the closing number of the *Bulletin* of the Isaac Ray Medical Library which is housed in Butler Hospital.

In a letter Dr. Babcock writes: "We are

hoping that the Isaac Ray Medical Library can remain intact and if this could be accomplished, perhaps the *Bulletin* can be resumed later on under other auspices."

We echo those hopes.

Amendments to By-Laws.—As stated on page 13 in "Reports of Meetings of Council" of the May 1955 annual meeting, Council recommended to the membership the adoption of an amendment to the By-Laws as follows:

Paragraph 3 of Article I of the By-Laws be amended by deleting the first four words thereof, that is, by deleting the phrase, "On the third day," and replacing it with the words "On the second day," so that as amended the first clause of this paragraph will read: "On the first or second day, elections to the different classes of membership in the Association shall be held." The remainder of Article I of the By-Laws is unchanged.

NAMH Manual for Police Officers.—A pamphlet entitled *How to Recognize and Handle Abnormal People,* written especially for police officers, is now available from the National Association for Mental Health. Descriptions of the typical behavior of psychopaths, alcoholics, drug addicts, and sex offenders are given, along with instructions as to how the policeman can deal with these abnormal persons should he encounter them in his daily round. Copies may be purchased at 65 cents each from the Association at 1790 Broadway, New York 19, New York.

Psychiatric Nursing Consultation.—A brochure of this title, being the report of the Institute for Nursing Consultants in Psychiatry held under the auspices of The American Psychiatric Association, committee on psychiatric nursing, May 26-29, 1954, at Princeton, New Jersey, is now available from the Central office of the Association, 1785 Massachusetts Avenue, N. W., Washington 6, D. C., at 50 cents per copy.

Fulbright Foreign Study Awards.—Fulbright scholarships for graduate study abroad are open to professional persons not now engaged in college or university study. Any U. S. citizen, between the ages of 18 and 35 with a bachelor's degree, is eligible. Applicant must be at the pre-doctoral level.

Opportunities for study are offered in the following countries in which the Fulbright program operates: Australia, Austria, Belgium and Luxembourg, Burma, Ceylon, Chile, Denmark, Egypt, Finland, France, Germany, Greece, India, Italy, Japan, the Netherlands, New Zealand, Norway, the Philippines, and the United Kingdom.

Closing date for applications for the 1956-57 academic year is October 31, 1955. Candidates-at-large may apply directly to the Institute of International Education, 1 East 67th Street, New York City.

Connecticut Postgraduate Seminar in Psychiatry and Neurology.—The ninth Connecticut Postgraduate Seminar will begin September 26, 1955, and continue through May 7, 1956.

From September 26 through December 5, 1955, sessions in clinical neurology, neuroanatomy, neurophysiology, and neuropathology will be held on Mondays and Wednesdays from 3:00 to 9:00 p.m. at Yale University School of Medicine.

From January 9 through March 5, 1956 (Mondays), from 3.00 to 10:00 p.m., sessions in general psychiatry (psychopathology, clinical psychology, therapy, psychosomatic medicine, geriatrics, and psychiatry and law) will be held at the Connecticut State Hospital, Middletown.

March 12 through April 16 (Mondays), from 6:30 to 9:45 p.m., a course in child psychiatry, and April 23 through May 7, 1956 (Mondays), from 4:30 to 10:00 p.m., a course in pediatric neurology will be given, both at Yale University School of Medicine.

There are no fees for these courses. Copies of the program may be obtained from the Office of the Assistant Dean for Postgraduate Medical Education, Yale University School of Medicine, 333 Cedar Street, New Haven, Connecticut.

Child Psychiatry in New York City.—Mrs. Henry A. Loeb, president of the Council Child Development Center announces that an advanced training program dealing with the psychiatric problems of pre-

school-aged children will be instituted in the autumn, 1955, for experienced mental hygiene workers. The new program will be financed by a gift from the Grant Foundation, which totals $72,000, inclusive of training costs. Two-year fellowships for psychiatrists and 4 social workers and 2 one-year fellowships for nursery school teachers, each fellowship part time, will become available. Psychiatrists will be required to be qualified for the specialty boards in psychiatry and to have prior training and experience in child psychiatry. Similar advanced professional standards would be required for the psychiatric social workers and the nursery school teachers. The Center is located at 227 East 59th Street.

American Neurological Association.—At the eightieth annual meeting of this association held in Chicago from June 13-15, 1955, the following officers were elected: president, Dr. J. M. Nielsen; president-elect, Dr. H. Houston Merritt; first vice-president, Dr. James W. Kernohan; second vice-president, Dr. Robert B. Aird; secretary-treasurer, Dr. Charles Rupp; and assistant secretary, Dr. William F. Caveness.

American Association for the Advancement of Science.—A 2-day symposium entitled Physiological Bases in Psychiatry will be held as part of the program of the AAAS on December 27 and 28, at Atlanta, Georgia. The symposium will have 4 sessions: New Psychopharmacologic Agents, Mechanisms of Action in New Agents, Effects of Alcohol on Brain, Respiration and Metabolism, and Alcohol Addiction-Mechanism, and Treatment.

Those wishing to take part in this program please contact either Harold E. Himwich, M. D., Galesburg State Research Hospital, Galesburg, Ill., who is a representative of The American Psychiatric Association, or Fred A. Hitchcock, Ph. D., Ohio State University, Columbus 10, Ohio, who is a representative of the American Physiological Society. The proceedings of these meetings will be published in an AAAS monograph.

New York State Department of Mental Hygiene.—The Department has authorized the construction of a new school for retarded children in the town of West Seneca, which is near Buffalo, New York. The cost will exceed 30 million dollars.

This new institution is the first of 4 of the Department's new building program, for which a 350-million-dollar bond issue was approved last year.

The new school will accommodate 2,400 patients with facilities for expansion to 3,000.

History of Tuberculosis in Mental Patients.—A valuable historical and bibliographical review on tuberculosis in mental illness by Dr. E. R. N. Grigg appears in the *Journal of the History of Medicine and Allied Sciences*, 1955, Vol. 10, No. 1 The article runs to 50 pages and is illustrated.

Dr. Nolan Lewis Donates Library to N. J. Neuro-Psychiatric Institute.—The valuable personal medical library of some 12,000 volumes, collected by Dr. Nolan D. C. Lewis, has been donated by him to the New Jersey Neuro-Psychiatric Institute, Princeton, N. J., of which he is director.

Dr. Aldrich Heads Department of Psychiatry, University of Chicago.—Announcement has been made that Dr. C. Knight Aldrich, associate professor of psychiatry and neurology at the University of Minnesota, is relinquishing that position to become professor and head of the department of psychiatry at the University of Chicago.

Dr. Rado Retires from Columbia.—Dr. Sandor Rado has retired from his position as Director of the Columbia Psychoanalytic Clinic for Training and Research. In his honor a Lectureship has been established in the Department of Psychiatry, College of Physicians and Surgeons, Columbia University. Dr. Abram Kardiner has succeeded Dr. Rado as Director of the Clinic, commencing July 1, 1955.

The 13th Annual Conference of the American Group Psychotherapy Association.—The 13th Annual Conference of the American Group Psycotherapy Association will be held Friday and Saturday, January 13 and 14, 1956, at the Henry

Hudson Hotel, 353 West 57th Street, New York City.

Six all-day workshops, dealing with special topics, will meet from 9.00 a.m. to 3.00 p.m. on January 13. For these, special registration will be required. Three scientific sessions will be held, beginning Friday, at 3.30 p.m., through Saturday, 5.30 p.m. For the morning of Saturday, January 14, 6 roundtables have been arranged. For further information inquire at the Association's office, 228 East 19th Street, New York 3, N. Y.

Major Williams Consultant to Surgeon General USAF.—Major Robert L. Williams, USAF (MC), formerly chief of the neuropsychiatry service and Neurological Center at Lackland Air Force Base Hospital, San Antonio, Texas, was recently appointed consultant in neuropsychiatry to the Surgeon General USAF, succeeding Dr. Edward Kollar who left the service to accept a civilian appointment.

Midwest Regional Research Conference.—This conference, a regional meeting of The American Psychiatric Association, is being held in Galesburg on September 16-17, 1955, under the co-sponsorship of the University of Illinois and the Galesburg State Research Hospital. The theme of this meeting will be "The Newer Psychopharmacology."

Society of German Neurologists and Psychiatrists.—The Congress of the Society of German Neurologists and Psychiatrists will be held in Hamburg, Germany, September 19-22, 1955. The main subjects on the program are: Motility and Motoric Behavior, and The Training of the Neurologist. For information write: Dr. Magun, Nervenklinik, Hamburg-Eppendorf.

Institute of Psychiatric Treatment, Boston.—This annual Institute will be held at the Boston State Hospital, September 29 through October 1, 1955, under the direction of Leo Alexander, M. D., and Robert Arnot, M. D. There will be morning and afternoon sessions daily, with luncheon served at the hospital. The faculty has been considerably enlarged this year to include new speakers.

On the first day the main topics will be electroshock and the new drugs, Serpasil and Thorazine; on the second day, other treatment procedures including in- and outpatient management, rehabilitation, and office practice; on the third day, the integration of physical therapies and psychotherapy. On Friday evening, September 30, there will be a dinner at the Harvard Club.

Registration fee, 35 dollars. For hotel reservations write to the Parker House where rooms have been set aside. Address correspondence to 433 Marlborough St., Boston, Mass.

Oberndorf Bequest to Cornell.—Dr. Clarence P. Oberndorf, who was graduated from Cornell University in 1904 and from its Medical College in 1906, was one of the first private practitioners of psychiatry in the United States. At his death last year at the age of 72, he left a bequest of more than $400,000 to Cornell University for the support of psychiatric service to the students of the University.

BASIS FOR RESEARCH

The art of investigation is the cornerstone of all the experimental sciences. If the facts used as a basis for reasoning are ill-established or erroneous, everything will crumble or be falsified; and it is thus that errors in scientific theories must often originate in errors of fact.

Men who have excessive faith in their theories or ideas are not only ill-prepared for making discoveries, but they also make poor observations.

—Claude Bernard

BOOK REVIEWS

Power of Words. By *Stuart Chase and Marian Tyler Chase.* (New York: Harcourt, Brace & Co., 1954. Price: $3.95.)

Stuart Chase says, "I have been uneasy about the meaning of words ever since I began to write." The great pity is that those who share his uneasiness are presumably a small minority among the writers, and, worse still, a negligible number among the talkers. Everybody talks, nearly everybody writes, if only letters; but how many consider the meaning of the words they use, whether they are promoting or hindering communication, their power for good or ill? A word may be balm of Gilead to a wounded spirit, it may be the unique spur needed to drive the hesitant one to achievement, it may be as poisonous as snake venom. Conscientious pondering the faculty of language each one possesses might wholesomely lead to a greater appreciation of the advantages of silence.

The author published his first semantic study, *The Tyranny of Words,* in 1938. That work, as he tells us, was chiefly concerned with the misuse of language. The present one deals with the positive as well as the negative side, the use of words as a means of communication, "how to say what we mean, how to evaluate what we hear."

The author reminds us that all organization and disorganization in human society depend on the tool of language, its use and misuse. The purpose of his book is to point out the ways in which language, as the means of communication, fails, and means by which communication can be improved and human welfare thus enhanced. For background he has something to say about the function of the nervous system in the business of communication, and goes from there to "machines that think." The means by which other animals communicate is discussed as preliminary to the evolution of language in the human child.

In a chapter on linguistics the author explains how language changes and grows like any other living thing, how canonized words become decanonized and slang becomes legitimate. The street-man is caught between the rigid grammarian who tells him once and for all the right words to use and the everyday loose talker who without knowing it is helping to create the speech of the future.

Stuart Chase speaks of James Joyce in his ultra-linguistic experiment, *Finnegans Wake,* as the "sad case of an authentic genius out of bounds." It was a noble experiment, nonetheless, and it might be questioned whether one is completely literate who has not at least gained something from *Finnegans Wake.* But there was a certain fatality about this work. It was Joyce's last work. It had to be. He could not have pushed his linguistic experiment further.

Language, the author tells us, is not only a means of expressing thought or the lack of it but is "a shaper of thought itself. Shaping the thought, it helps to shape the culture. . . ." He warns against meaningless questions—unquestions, we might call them, such as, Where is the edge of space? Has time a beginning and end? Where was I before I was born? And, *per contra,* Where shall I be after death?

Semantics is naturally the keynote of the book we are discussing and to this special discipline the author gives ample attention, with particular reference to the great work of Korzybski. In a section entitled "Twenty-one Statements in General Semantics," he usefully summarizes the main principles set forth by Korzybski in his monumental work, *Science and Sanity,* which Chase admits he found rather difficult reading. As a result largely of Korzybski's teaching, some readers may be surprised to learn, courses in semantics were being given by 1953 in more than 100 American universities.

The richest fields for semantic exegesis, as the author points out, are the double-talk of campaign oratory and the upside-down talk from Moscow, with the incredibly crude outpourings of the soviet propaganda machine. He gives some painful examples of globbledygook, a word, we learn, that was coined by Congressman Maury Maverick of Texas as applying to the ponderous wordage of government departments in Washington. For those who need the demonstration examples are given of verbal monstrosities that by judicious surgery can be made to convey their messages with greater clarity and at much smaller expense of language.

Speech, then, is the essential means of communication, and mutual understanding depends on good will and satisfactory communication based on shared meanings. "Meaning is relative to experience, and for a message to be understood, there must be an overlapping of experience between sender and receiver." There can be no doubt that the communication systems in our world today are sadly out of order. Their correction would promote mutual understanding at all levels—between individuals, in families, in communities, between nations. This book is a contribution toward that desirable end.

C. B. F.

Current Problems in Psychiatric Diagnosis. By *Paul Hoch and Joseph Zubin.* (New York: Grune & Stratton, 1953. Price: $5.50.)

The problem of diagnosis is too often summarily dismissed as one of "labelling" or "elementary semantics." A diagnosis is a shorthand way of saying something which may be very complex. Such a shorthand procedure is not only logically valid but practically imperative in psychiatriy *if,* and I cannot too strongly emphasize the "if," all are agreed as to

the exact nature and significance of the complex or longhand statement. Today we find ourselves in the anomalous, not to say humiliating and ridiculous, position of being in almost unanimous agreement with regard to the shorthand diagnostic label, and yet engaged in internecine warfare over the meaning and significance of the longhand complex.

The complexity of the diagnostic process is presented in erudite yet eminently readable form in this collection of papers. I particularly liked the discussion of the function of diagnosis and also the cautionary comments about phenotypical and genotypical modes of definition and diagnosis. The book presents a historical review of the concept of diagnosis and also some stimulating research ideas and contributions. The material covered is comprehensive in scope and catholic in view-point. The editors are to be congratulated not only for efficiency in their function but also for their own contributions in discussion. Among such a host of brilliant names it is perhaps invidous to make distinctions but I cannot resist mentioning Ewen Cameron's fine contribution. In brief, this work is a "must" for all to whom diagnosis is a fascinating matrix of history and prediction and not a labelling "chore"—a species of Cinderella-function tyrannised by the ugly sisters of dynamics and treatment.

F. G. E.

Progress in Neurology and Psychiatry. Edited by *E. A. Spiegel, M.D.* New York: Grune & Stratton, 1954. Price: $10.00.)

In the 1954 edition of *Progress in Neurology and Psychiatry* some 3,700 papers are reviewed by 66 authorities. As in previous volumes the annual review is divided into 4 sections: basic sciences, neurology, neurosurgery, and psychiatry, with 35 chapters devoted to every aspect of these subjects. Doctor Spiegel, as in the past, has seen to it that there is a balanced picture in which each discipline is afforded a fair representation. Many of the chapters are more than summaries of recent work, the reviewers making critical and stimulating comments. In the psychiatry section alone, there are 15 chapters dealing with psychology, clinical psychiatry, mental hygiene, forensic psychiatry, criminal psychopathology, child psychiatry, the neuroses, alcoholism, psychosomatic medicine, psychoanalysis, clinical psychology, group psychotherapy, physiodynamic therapy, psychiatric nursing and occupational therapy, and rehabilitation. The article on psychology is a special one and devoted to the most important developments in psychology during the last 5 years.

This most recent edition of *Progress in Neurology and Psychiatry* does not claim to be all-inclusive but offers an extensive sampling of the literature and maintains the high standards of previous years.

John G. Dewan, M. D.,
University of Toronto.

Year Book of Neurology, Psychiatry and Neurosurgery. 1954-55 Series. By *Roland P. MacKay, M.D.* (*Neurology*), *S. Bernard Wortis, M.D.* (*Psychiatry*), *Percival Bailey, M.D.* (*Neurosurgery*). (Chicago: The Year Book Publishers, 1955. Price: $7.00.)

Introducing the section on Neurology, MacKay notes the important developments during the year. Study of the antibiotics in the treatment of infections of the brain and meninges has actively continued.

In connection with vascular diseases, especially noteworthy are studies of collateral circulation—"which, contrary to a former belief, is considerable in the brain—in cases of vascular occlusion."

Work on the degenerative diseases has yielded small but significant returns. In many cases they appear to be due to metabolic deficiencies as in the handling of certain trace metals, e.g., the metabolism of copper in Wilson's disease. In other conditions such as amyotrophic lateral sclerosis and multiple sclerosis, genetic factors seem to play a part. The importance of genetics in neurological diseases, in particular the degenerative diseases, was emphasized at the December 1953 meeting of the Association for Research in Nervous and Mental Disease.

Work in progress by Salk during 1953 and 1954 on immunization against poliomyelitis is reported in this section.

The section on psychiatry has changed hands. Nolan Lewis, who admirably conducted this part of the Year Book covering work from 1939 to 1953 inclusive, felt that he had served his turn, and has been succeeded by S. Bernard Wortis.

Among notable trends in psychiatry during the recent past, Wortis finds a greater interest in sociologic and environmental factors in mental health and illness: increasing concentration on physiologic research and on physical and psychical relationships; recognition of the urgent need for evaluating comparatively the effectiveness of the various treatment procedures, physiological and psychological, now in use; increasing interest in child psychiatry, notably childhood schizophrenia.

Conversely, Wortis notes a dearth of publications dealing with dynamic concepts and with clinical, industrial and preventive psychiatry. Papers reporting in detail the psychodynamics of individual cases "often tend to conform to a regular framework of dynamic concept," and only occasionally is such an article found abstracted in the reviews.

A separate chapter (68 pages) is devoted to Therapy. Among specific treatment media covered are: chlorpromazine, isoniazid, lysergic acid diethylamid, electroshock with succinylcholin, insulin, carbon dioxide, and others, together with various combined measures. Neurosurgery receives considerable attention in the psychosurgery section.

The special section on Neurosurgery is introduced by Editors Bailey and Sugar by calling attention to the medico-legal implications of psychosurgery. They take note of the order prohibiting lobotomy in the U.S.S.R. and also of certain strictures by the Pope on "medical experiments or re-

search when they entail serious destruction, mutilation, wounds or perils." All new treatment methods, including the so-called "drastic" therapies are experimental when first tried and these are indispensable to the progress of medicine; and the Editors remind us that the American Medical Association has laid down rules governing new and experimental procedures, which safeguard the patient and also the physician and others concerned.

The vast area of modern Neurosurgery is well covered by the material abstracted. Prefrontal lobotomy is not comprehensively dealt with since this and kindred operations are done mainly for psychiatric reasons and the subject is reviewed in the preceding section.

The diagnostic value of angiography is emphasized in numerous reports, and brain tumor studies are abstracted from some 30 papers.

The text of the Year Book runs to about 600 pages (200 to each section). In addition to the value of the material presented, the convenient format (5 x 7½ x 1 inches), excellent printing job, generously illustrated in the sections on Neurology and Neurosurgery, and the whole fully indexed, make this volume the most useful ready-reference work in its field.

C. B. F.

Rorschach Interpretation: Advanced Technique. By *Leslie Phillips, Ph. D., and Joseph G. Smith, Ph. D.* (New York: Grune & Stratton, 1953. Price: $9.25.)

The Foreword frankly states that this book is "composed largely of statements about relationships between Rorschach performance and other behavior," and that "most of these relationships represent guessed-at laws . . . best employed with equal parts of faith and skepticism."

Considered in this light and not as a definitive source of diagnostic specifics, the text is a useful contribution to the Rorschach literature, representing the extensive experience and impressions of the authors. It is essential to emphasize this point, since the title "Advanced Technique" may indicate to some readers that here is the last word. That it is not the last word can be demonstrated by statements like: "The underproduction of M represents the absence of empathic responsivity and may be a function either of a) fixation at or regression to a genetically low level of perception or b) a restriction of function in response to interpersonal difficulties." This is sometimes true, but in many hundreds of cases of apparently normal persons who seem to be getting by, records will be given in which there are no human movement responses and yet no clinical evidence of any type of restrictive or regressive variant of psychopathy can be shown.

Probably the best approach to this book, therefore, is simply to accept the fact that it represents a viewpoint and that the authors' statements, especially in terms of clinical meaning, may be true in some cases and not in others.

On the positive side, the authors have done a great deal of good work in analyzing the literature, particularly in discussing form levels, movement responses, and especially the use of color. Here they have not only reviewed other authorities, but have interwoven their information with their own experience and produced some really useful material.

The section on Content Analysis is also handy, since it represents alphabetical classification of frequent responses which can be easily looked up. The hazard here in adapting from the text a meaning for an individual response is higher than in any other section, since what may be significant to one person may be coincidental to another. Generally, such "dream book" interpretations are risky and this section of the book should be approached with greatest caution.

The latter part of the text presents an intriguing discussion on general attitudes and role playing as restricted to Rorschach responses, and is a useful contribution. The section on Shock tends to suffer from overemphasis on timing, but otherwise is good. Sequence Analysis is reasonably well demonstrated, and the final long Case Analysis is well done. The authors have included some tables of form levels which will actually be more helpful to the beginner than the expert, and there is a good Index.

In general, the merits of the book, outweigh the potential hazards—hazards which the authors of course cannot prevent, since they are inherent in students who tend to accept as gospel, any written word. If the title were changed to read "Rorschach Speculations—Our Method," it could be highly recommended.

Douglas M. Kelley, M. D.,
University of California.

Films in Psychiatry, Psychology, and Mental Health. By *Adolf Nichtenhauser, Marie L. Coleman, and David S. Ruhe.* (New York: Health Education Council, 1953. Price: $6.00.)

This book of 269 pages contains the results of study of films in psychiatry, psychology, and mental health from the viewpoint of the medical educator, the study having been conducted by the Medical Audio-Visual Institute of the Association of American Medical Colleges. The book consists of 4 parts. Part I contains a gallery of scenes from a few of the films studied; Part II, a discussion of film-reviewing techniques and suggestions for the utilization of films in teaching psychiatry and psychology and in public education; Part III, much the largest part, reviews of 41 films; and Part IV an index to titles of 50 other films, an index to subject matter, and a suggested guide as to the suitability for various types of audience of each film reviewed in the book.

As films in these areas are being widely used, it is helpful to have readily available in permanent form a list of those bearing most directly upon aspects of psychiatry, psychology, and mental health. Reviews of the 41 films are lengthy, detailed, and stimulating. To any one who has been concerned with the making of a film in one of these areas, or who is thinking of making such a film, this book

is of special interest. A chapter on "How Content and Presentation Influence Each Other" is excellent.

It is to be hoped that supplements to this volume, or new editions, will be issued as new films become available. More careful proof-reading, make-up, and editing in subsequent editions will avoid some minor irritating features of the present one, which is nevertheless highly recommended to those concerned with training psychiatrists, psychologists, social workers, teachers, the clergy, and other groups concerned with human relationships, as well as to those concerned with public education in mental health matters.

CHARLES STOGDILL, M. D.,
Toronto, Canada.

KONVERSION UND REVERSION KLINISCHER NEUROSEN. By *Hans Rehder*. (Köln: Aerzte Verlag, 1953.)

European literature on psychopathology and psychotherapy is usually quite different from that of the northern part of the Western hemisphere. Whereas here the so-called dynamic approach dominates the field, a great diversity in basic philosophy and technical methods characterizes the European writers.

Very little of their broad eclectic humanistic thinking is to be found in Rehder's book. The author is a gastroenterologist who in the course of 40 years of experience naturally has encountered a wide variety of neurotic patients. He, himself, did suffer from and has successfully overcome a neurotic affliction. He has attempted in his book to crystallize his experiences and to systematize them into his own special theory of neurosis and into his own special brand of psychotherapeutic technique. He has approached the field of neurosis and psychotherapy as if it were virginal territory, ignoring the contributions of the past. Unfortunately, he has, however, employed familiar terms, like libido, anxiety, and conversion, without using them in sense commonly attributed to them. He fails completely to differentiate between fear and anxiety. These shortcomings together with the tendency toward repetition and an unclear method of presentation make the task of the reader and reviewer rather difficult. Once the reader has overcome these difficulties he will find good clinical observations, independent although not always clear thinking, therapeutic intuition, and a warm spirit of human understanding.

The essential factor that the author tries to bring out consists in his emphasis on the short span of the conversional process. Under this he understands the act in and by which the "harmony" of a person is being lost (the author's concept of "harmony" equals something which may be best described as a state of emotional well-being and unimpaired psychological functioning). Rehder rejects the customary tendency to attempt a biographical study. Rather, he concentrates on a slow-motion investigation of the usually very short periods of the conversional process, when under the impact of external forces the initial disturbance of "harmony" takes place. The subsequent development is characterized by a fast sequence of various stages. The original disturbance of "harmony" also designated as "provocation" results in overwhelming fear. The individual perceives a disturbing change in well-being. The interest in the outside world diminishes, and the patient concentrates on his disturbed "harmony." This stage is called "emotion." Then follows a gamut of various other stages like "accumulation," "error," (the patient confuses suffering with illness), "sensibilization," "pavor," "terror."

The author's theory and technique concentrate on detailed exploration and interpretation of these various phases of the conversional process. Not only antecedent biographical factors but also constitutional elements are being purposely ignored. Understanding of a neurosis and its cure comes from a step-by-step exploration of the conversional act. The leitmotiv of the therapeutic process is the slogan: "Who converts can also revert." Insight paves the way towards reversion. The author's case histories indicate that he has achieved good therapeutic results with his method.

The general psychiatric reader will find himself not particularly interested in this book. The student of the various ramifications of psychotherapeutic theory and practice will not want to overlook it, but will find his reading pleasure considerably curtailed by the above enumerated shortcomings.

A. GALLINEK, M. D.,
Columbia Presbyterian Medical Center,
New York City.

ESSENTIALS OF ABNORMAL CHILD PSYCHOLOGY. By *Ernest Harms*. (New York: Julian Press, 1953. Price: $5.00.)

In this book Ernest Harms presents his views of the psychological disturbances which occur in childhood. He states frankly that his viewpoints are quite different from those of most psychiatrists and psychologists working with children, and documents his reasons quite extensively.

He makes some important points with regard to prejudices and preferences as they influence individual opinion, since what is normal for one nationality or group may be abnormal for another; that children should not be measured in adult terms; and that the aim in psychotherapy is the cure of the cause, rather than the symptoms.

Although he favorably reviews Adler's theory of the inferiority complex and the superiority complex, and Jung's theories on the child's inferior position in the family of adults, he is inclined to underestimate the contributions of men such as Freud and Gesell. This is unfortunate, because they have written material which has been and still is of inestimable value in the study and understanding of the development of the child.

His style is difficult, which does not contribute to easy understanding. Some of the chapters are reprints of papers Dr. Harms has previously published. One chapter is devoted to a detailed descrip-

tion of the Harms-Beth David Guidance Clinic and its forms.

As a record of one man's opinions, derived from his own experience and not especially correlated with that of others, the book may serve as a critical résumé for readers of wide experience.

L. G. L.

PSYCHANALYSE ET ANTHROPOLOGIE. By *Marie Bonaparte.* (Paris: Presses Universitaires de France, 1952. Price: 400 fr.)

The papers collected in this volume, with the exception of the last one, have been previously published by the author in psychoanalytic journals. Not all of them are anthropological in the narrow sense. The book includes some important psychoanalytic contributions to clinical problems; *e.g.*, the study of the famous case of Mme. Lefebvre who killed her daughter-in-law; the case of the identification of a daughter with her dead mother; and the paper devoted to self-aggressive activities, such as nailbiting. In the other articles the psychoanalytic approach has been applied more specifically to anthropological problems; the studies on head-hunting and on the relationship between ethnography and psychoanalysis are especially noteworthy.

RUDOLPH M. LOEWENSTEIN, M. D.,
New York City.

PSYCHANALYSE ET BIOLOGIE. By *Marie Bonaparte.* (Paris: Presses Universitaires de France, 1952. Price: 400 fr.)

Although this collection of articles is not devoted exclusively to the relation of psychoanalysis and biology, it gives renewed evidence of the biological emphasis which characterizes the author's general approach to psychoanalysis. Of particular importance among these valuable papers, in the opinion of this reviewer, are those dealing with female sexuality and its disturbances, and the short but excellent report on the psychoanalytic discovery of the primal scene. At a time when so much attention is being given to psychosomatic medicine, the reader will find much food for thought in the concluding paper of this volume; here Marie Bonaparte cautions against overenthusiasm and stresses the "limits of psychogenesis."

RUDOLPH M. LOEWENSTEIN, M. D.,
New York City.

DIE DYSTROPHIE ALS PSYCHOSOMATISCHES KRANKHEITSBILD. By *Kurt Gauger.* (München: Verlag Urban und Schwarzenberg, 1953. Price: $14.80 D.M.)

Those who have undertaken the reorientation of prisoners-of-war or displaced persons will welcome this careful study of the various factors, tangible and intangible, at work in the dystrophic patient. Few of the ex-service men (the "late homecomers") and displaced persons treated by Gauger had enjoyed the freedom of movement, and indeed the occupational therapy, that became usual in the P.O.W. camps in the United States and in England as the war progressed; in some theaters of war those who had meted out scant mercy received little in return. How their reactions to frustration and social injustice come to resemble those of Michael Kohlhaas are strikingly shown in a reference to the characters of von Kleist's famous historical novel.

Dystrophy is peculiarly the illness of the prisoner-of-war; when he is behind the wire, during the difficult months immediately after his release, and often for years, unless he is offered and responds to adequate treatment. For some years after World War II Kurt Gauger was chief medical officer of the clinic for returning P.O.W.'s at Fischerhof, near Uelzen, for long the only one of its kind in Germany, and in this book he sets out to shed light upon the problem of the returned man, in its medical-psychological aspects. Perhaps the somewhat overworked word "problem" is in this instance preferable to "riddle"; for the forces here at work seem often deep-rooted and imponderable rather than readily accessible. Those who have attempted to rehabilitate prisoners of any kind should not rest until they have persuaded their German-speaking colleagues to translate for them some parts of this stimulating book.

Gauger's main thesis is that the returned man, misunderstood and misunderstanding, is sick rather than criminal, although he frequently finds himself in conflict with the Law; and the author has the great advantage of having been himself for a time a prisoner-of-war.

Dystrophy has a quite banal cause—quantitative and qualitative undernourishment; too few calories and too little albumen. The visible physical symptoms are well known. Yet judges and sociologists are puzzled by the large number of men who, after they have been restored to their families, find themselves in conflict with society, in the divorce courts, or charged with indecent assault. After a few weeks it becomes clear that the home-comer is unable to find his way back into the old world of civil life; and that his task is rendered more difficult if he is not recognized and treated as a sick man. His illness remains, in its great weight and at its many levels, a hidden one, undiagnosed.

After World War II in particular, the importance of a nutritious diet was rightly stressed; yet mental disturbances seemed to be "working their way out" in an inexplicable way years after the barbed wire had been left behind. Thus Kurt Gauger sees the way of the hungering P.O.W. as a collective fate which almost always follows a similar course. It begins with the psychic shock of capture, a shock so severe that the prisoner feels like a person who has been lamed. Usually he does not feel hungry during the first days of captivity, and the high mortality in the so-called hunger marches is not a consequence of lack of nourishment, but of the depression of the victim. The prisoner enters the second phase after his first real meal in captivity. He awakes out of his original stupor and feels himself a prisoner whose urges are now concentrated on the mere struggle to keep himself alive. The urge to satisfy—his hunger takes grotesque forms—all sorts of con-

ceptions and possibilities of custom, morality, sexuality, comradeship, treachery, and even of religion mingle in an awful animal-like revaluation with the act of eating. The result is autism. He lives only for the moment, and is in a real sense no longer an individual human being: he is "a part of a hungering collective."

The family man is convinced that in the darkest days only the thought of his wife and children kept him going; yet the innumerable marital tragedies of the returning men indicate that already in captivity some morbid changes in the psyche had occurred which were not extinguished by the experience of liberation and return. *"Der Dystrophiker bezog sich nicht auf die Frau, er bezog vielmehr die Frau auf sich."* Gauger holds that these changes are partly responsible for the inability to revive old friendships, and the feeling that he is not understood. In a few years he may find himself with a "Michael Kohlhaas" problem, and this is why objective disturbances in dystrophy patients are so difficult to cure. He does not see reality; he sees only himself. He reproaches himself or defends himself where no one has assailed him: and so his justified advancements are transformed in a tragic way into unjustified reproaches.

The physical factors are thoroughly investigated, and explain the numerous and but slowly curable potency disturbances of the "pliant work-slaves." These, added to the mental cramp which often accompanies them, have thwarted the efforts of judges and social workers to remedy broken marriages and to rehabilitate moral delinquents. (Here *L'Astenza Sessuale*, by S. Fajrajzen, seems very relevant.) For men and women who have thus "gone off the rails" diet and support therapies are not enough. Kurt Gauger is convinced, both as physician and as philosopher in the wide continental meaning of that term, that the key lies in an understanding of the psychosomatic nature of dystrophy.

R. Cameron Fleming,
Dortmund-Aplerbeck,
Germany.

Our Common Neurosis. By *Charles B. Thompson, M. D., and Alfreda P. Sill.* (New York: Exposition Press, 1953. Price: $3.50.)

The material in this book derives from the early research in behavior analysis by the late Dr. Trigant Burrow. Early in the 'twenties group analysis was an innovation to investigate the norms and deviations in social relationships which in turn illuminated neurotic disorders of the individual.

From Dr. Burrow's (Lifwynn Foundation) social analysis it was felt that neurosis is not a disorder of individuals, but rather, a disorder of the social milieu. In other words the "normal" is neurotic; there is a common neurosis. The basic patterns of man are social and based on the right from his species phylobiology. These patterns are eclipsed by the artificial dictates of the social "I"—complex or "I" persona. The latter pattern, a dissociation found in "normality," is egocentric, exclusive, autocratic, and involves the defensive projection of interpersonal affect or prejudice. Early in life indoctrination of the "normal" nurtures another generation of neurotics. Hope for correction is felt to lie in the preconscious phase of development wherein the mother-infant relationship is a physiologic unity and not warped by the social "I"—persona. A vestige of this biologically fulfilling experience as the basis of certain aspects of human feeling may be found to be a means to a less neurotic social (and individual) life.

L. H. S.

Appraising Personality. The Use of Psychological Tests in the Practice of Medicine. By *Molly Harrower.* (New York: W. W. Norton, 1952. Price: $4.00.)

This book is an introduction to the practice and the resources of present-day clinical psychology, intended mainly for the physician who may wish to inform himself about the techniques of the new profession and their potential contribution to his own work. It is not a textbook of techniques but an information survey written for the members of a collaborative profession who have in common with the clinical psychologist the concern with maladjusted or psychologically disabled people but do not know about the viewpoint and the methods of clinical psychology. The book addresses itself to such questions as "What does the clinical psychologist do? What are these 'Projective Techniques' which he uses?" These and similar questions are answered in the first part of the book. In the second, some of the better-known psychological tests are being discussed and their method illustrated by means of characteristic case materials. The third part presents several case histories which serve to demonstrate what kind of insight the psychologist ellicits from his tchniques, how he reports them, and how they dovetail with other kinds of observation.

In order to approach this rather imposing task the first and second part are put in the form of a dialogue between a general physician and a psychologist, the third in the form of letters and case reports which are being exchanged between them. As far as the aim of this book is concerned, no other publication in recent years has accomplished it so successfully, with so much circumspection and good sense. In fact, nobody has quite recognized before the need for such an introduction, obvious though it should be, and has worked to provide it with appropriate scope. While discussing the diagnostic techniques and procedures of clinical psychology the book outlines a much greater subject: the appraisal of personality, its multiple dimensions and correlates. It proposes to discuss a specific area but in reality intimates something of the variety and autonomy of psychology. A number of charts and a clever selection of drawings illustrate and amplify the text.

One may not entirely agree with the author's selection of diagnostic devices, her approach to them, or her views on the profession of psychology. At the stage to which it has developed at present, clinical psychology needs disagreement and some intrasigence. No dissension would in the least inter-

fere with recommending this book to all who want to inform themselves about the diagnostic capacities of clinical psychology as the one with which to begin.

FREDERICK WYATT, PH.D.,
University of Michigan.

THE SIX SCHIZOPHRENIAS. By *Samuel J. Beck.* Research Monograph No. 6 (New York: The American Orthopsychiatric Association, Inc., 1954.)

This book is a fairly detailed report of several researches into the psychology of schizophrenia. The researches are pulled together by a common methodology and a single frame of reference. The latter resulted from many hours of discussion by a group of psychiatrists (Grinker, Spiegel, *et al.*) and psychologists (Beck, *et al.*) whose main task, both at the beginning and end of the research, was to direct themselves to the question, "What is schizophrenia?" The tentative answers resulting from the discussion were cast in terms of 4 major psychic functions: the defenses; the ego functions lost and primitive functions revived; the status of emotional forces; and the restitutional forces.

A set of 120 statements alluding to these functions was drawn up. Examples are: Has little energy; mood depressed; undirected flight of attention; confused; illogical thinking; fantasy a main source of defense; socially well enough adapted; etc. These items are the basic stuff of the researches. Selected cases of schizophrenia, both adults and children, were described by a psychiatrist and by psychologists who had access to the patients' Rorschach tests. The descriptions were made by sorting the same set of 120 statements in an approximately normal distribution along a continuum from "least characteristic" to "most characteristic" for each patient. These descriptions were intercorrelated and factor-analyzed according to procedures championed by Stephenson, who describes briefly the rationale of his methods in a chapter of the book and in an appended illustration.

Six patterns of schizophrenia are identified by these procedures. Unfortunately, Beck does not name them but identifies them as S-1, S-2, S-3, SR-1, SR-2, and SG. Such labels do not foster communication about them. S-1 and S-2 are said to be the advanced stages of the disease with intellectual disruption the most pronounced feature. These were not found in children under 10 years. S-3 is characterized by a defensive exterior and a brittle internal condition. SR-1 and SR-2 are "identified by the test and not by the psychiatrist." SR-1 features constriction, pathogenic defenses, disruption, and self-deprivation in the total adaptation. SR-2 is characterized by pathogenic-withdrawal defenses, coherent thinking, regressive fantasy, self-absorption in the total adjustment, and labile affectivity. SG is found only in children and is characterized by constricted defenses, fixed emotional tone, self-absorption, and little or no fantasy. SR-1 and SG are said to be the early forms of the disease found in children, and within 5 to 9 years the pattern changes to one of the more permanent reaction forms S-1, S-2 or S-3.

A book such as this is bound to provoke much criticism, both from the viewpoint of its method, its rationale, and its conclusions. For example, Beck distinguishes schizophrenia from psychosis. "To characterize a person as belonging in one of the six reaction patterns is not to say that he is psychotic." This will not sit well with many who think of schizophrenia as the prototype of functional psychosis. What Beck has in mind in making this distinction is the notion of latency. The schizophrenias "are a forecast of the kind of disorder to expect should the person break down to the psychosis level." This distinction raises many more questions than it answers.

Beck sees the common thread in the six schizophrenic patterns as one in which "the ego follows the path of least resistance." He talks of a "bimodality" in schizophrenia, meaning that the individual shows too little or too much of certain psychologic activities. These formulations do not seem to light up any new paths to our understanding of the basic question, "What is schizophrenia?"

A sophisticated, critical reading of the book presupposes some fair knowledge of schizophrenia from the clinical side; the Rorschach test; and research design with particular understanding of the Q-methodology of Stephenson. These criteria will limit the book's appreciative audience considerably. However, this is not a criticism of the book. It merely points out directions that both psychiatrists and psychologists must consider if they are to keep pace with the advancing field of psychopathological research. There are many points of interest raised in the book which readers will find rewarding. Workers with the Rorschach test will be particularly interested in both the research and diagnostic applications made of the test. On the whole, the book has much to commend it.

DAVID ROSENTHAL, PH. D.,
The Johns Hopkins Hospital.

CALIFORNIA SEXUAL DEVIATION RESEARCH. (Sacramento: Assembly of the State of California, 1954.)

This is a final report of a project authorized and financed by the California Legislature, extending from 1950 to 1954.

It is a veritable mine of information about sexual deviation. In one section there is a synopsis of special sex psychopath legislation in the 23 states and District of Columbia. This section alone should be of value in other jurisdictions contemplating legislative action.

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K. G. GRAY, M. D.,
University of Toronto.

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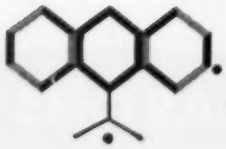

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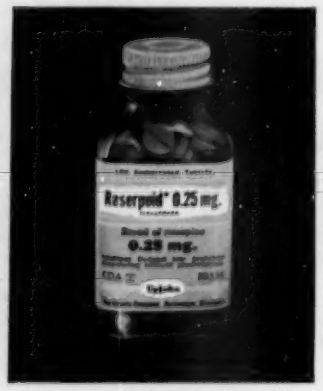

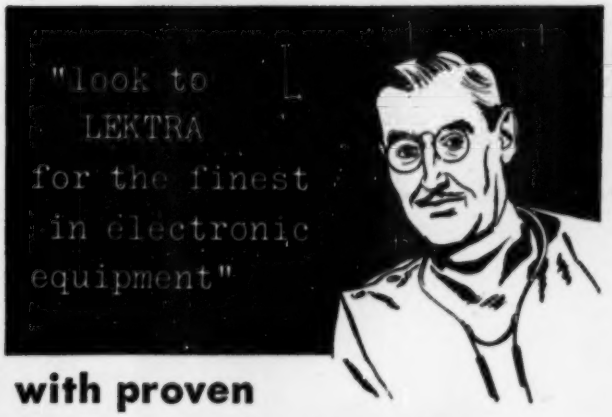

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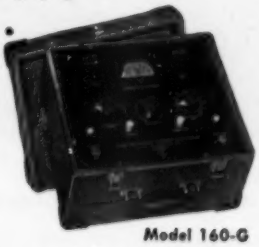

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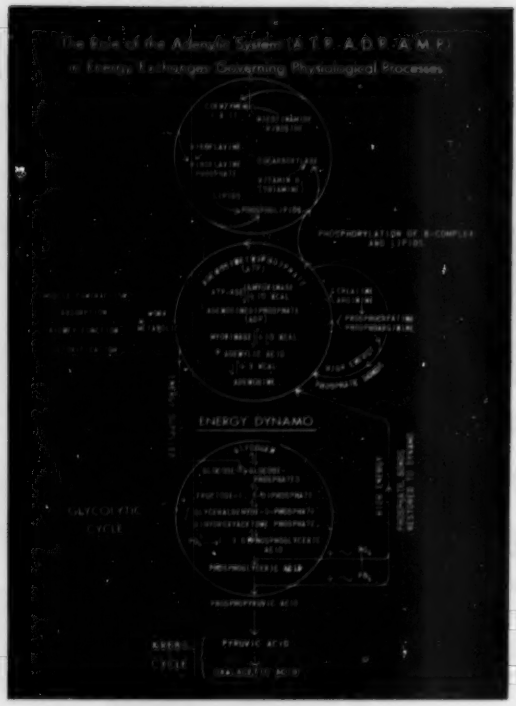

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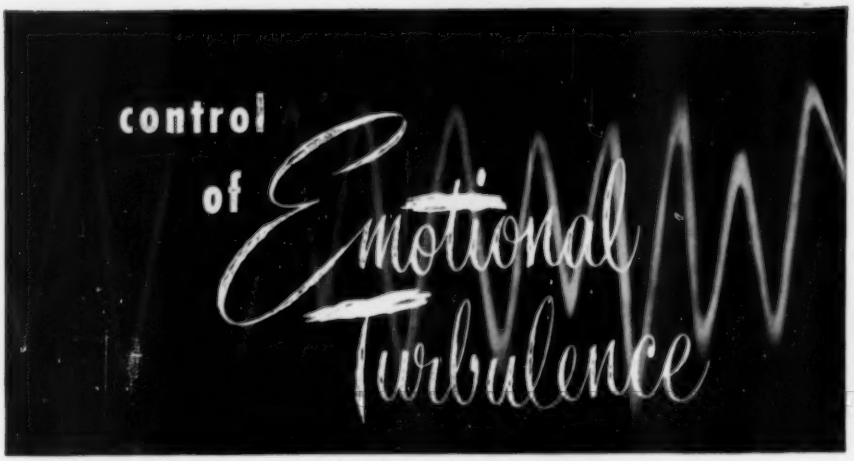

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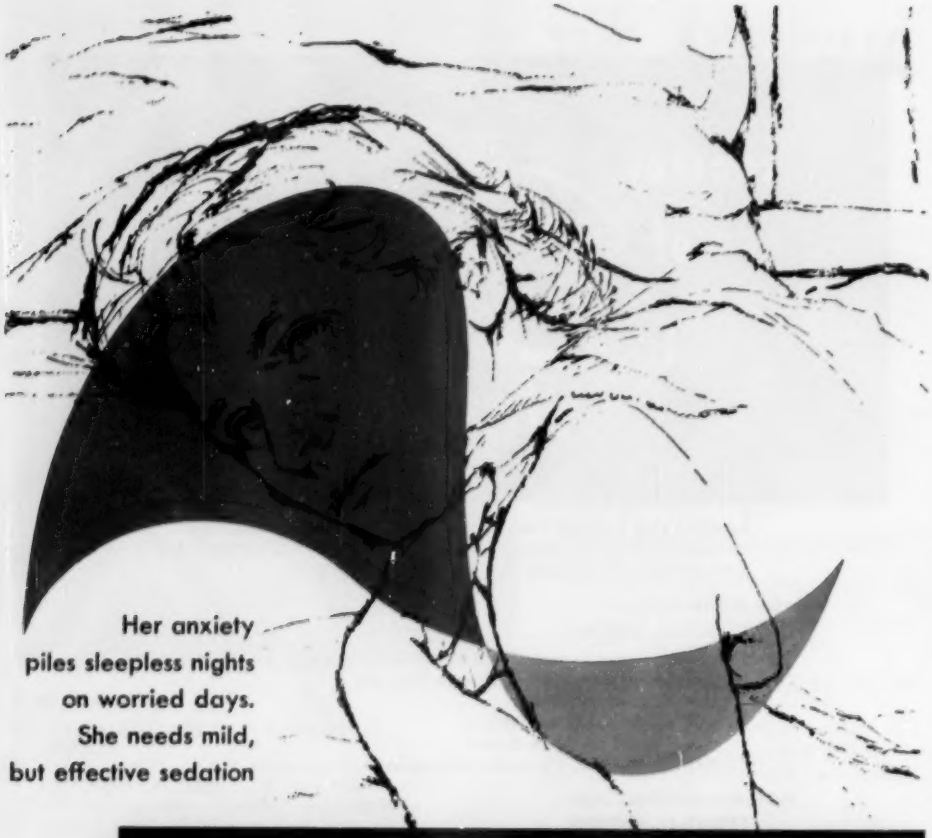

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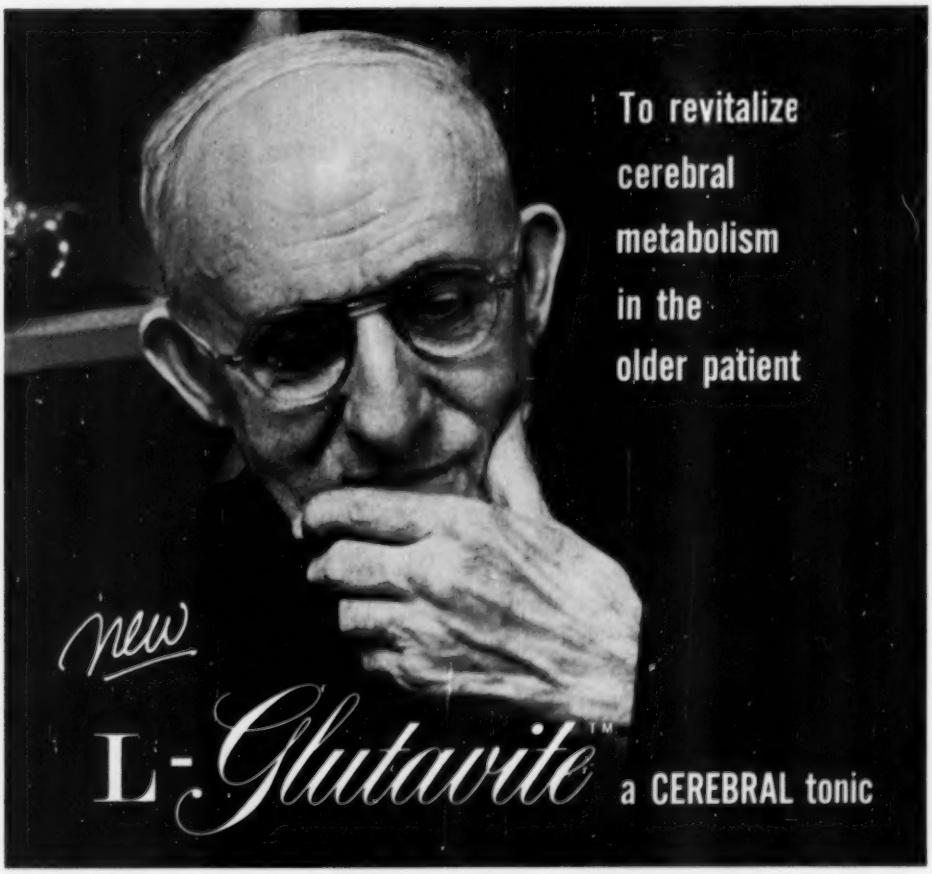

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1. Himwich H.E.: Paper presented at American Psychiatric Association meeting, St. Louis, May, 1954.
2. Lehmann, H.: 27th Annual Conference, Milbank Memorial Fund, New York, Paul B. Hoeber, Inc., 1952, p. 587.

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1. Saltzman, C., Konikov, W., and Relyea, R. P.: Dis. Nerv. System 16:153, *1955. 2. Nowill, W. K., Wilson, W., and Borders, R.: A.M.A. Arch. Neurol. & Psychiat.* 71:139, *1954. 3. Steven, R. J. M., Tovell, R. M., Johnson, J. C., and Delgado, E.: Anesthesiology* 15:633, *1954. 4. Holmberg, G., et al.: A.M.A. Arch. Neurol. & Psychiat.* 72:73, *1954. 5. Wilson, W. P., and Nowill, W. K.: ibid.* 71:128, *1954.*

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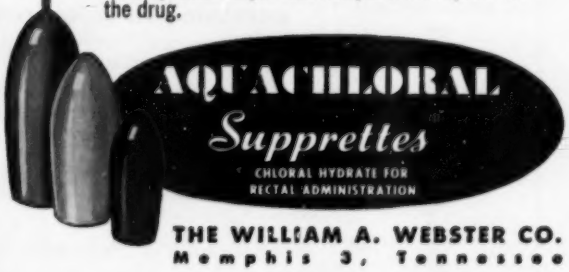

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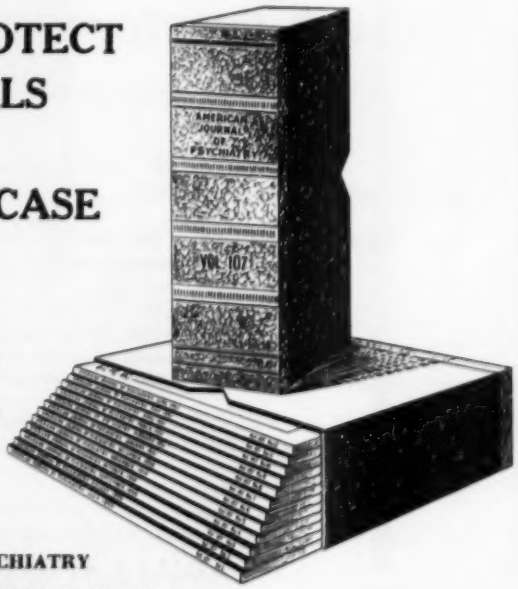

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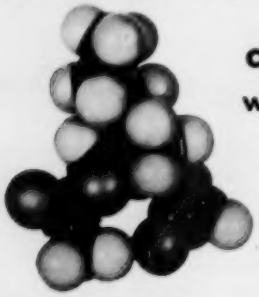

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1. Selling, L. S.: J.A.M.A. **157**: 1594, 1955.
2. Borrus, J. C.: J.A.M.A. **157**: 1596, 1955.

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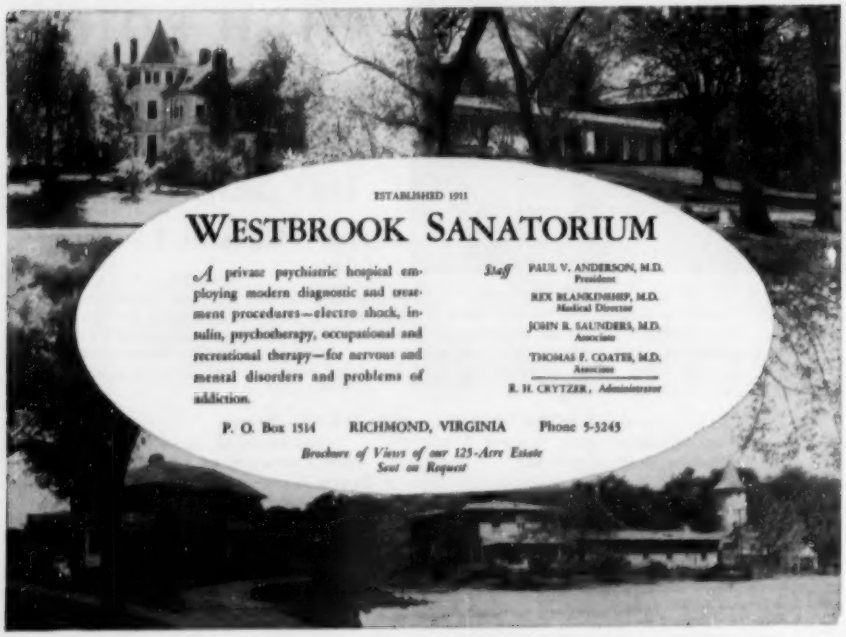

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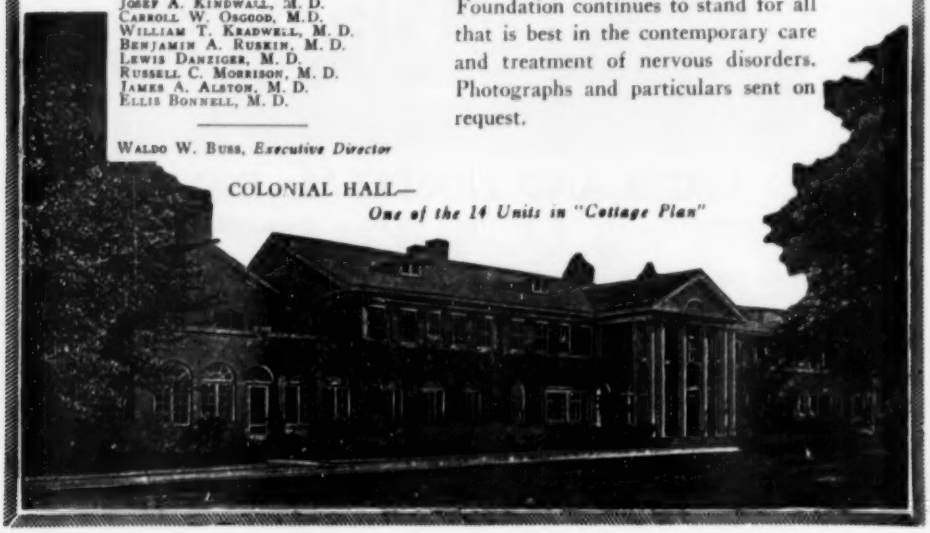

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